Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Equality Screening, Disability Duties and Human Rights Assessment Template

PFG DELIVERY PLAN - INDICATORS 2, 3, 4 & 7

Part 1 – Policy scoping

Part 2 – Screening questions

Part 3 – Screening decision

Part 4 – Monitoring

Part 5 – Disability Duties

Part 6 – Human Rights

Part 7 – Approval and Authorisation

Guidance notes are available to assist with completing this template. For further help please contact the Equality and Human Rights Unit ext 20539. [HE1/16/83070]

Part 1. Policy scoping

1.1 Information about the policy / decision

1.1.1 What is the name of the policy / decision?

Delivery plan arising from Programme for Government 2016-21 indicators 2,3,4 and 7

1.1.2 Is this an existing, revised or a new policy / decision?

New policy – Delivery plans will be the means through which actions are identified. As the approach to the overall Programme for Government is refined, this will influence refinement and improvement of delivery plans. The involvement of stakeholders in every stage of development and delivery, is essential to spirit of the OBA collective planning and implementation process.

This plan relates to the following indicators –

- Indicator 2: Reduce health inequality (Gap between highest and lowest deprivation quintile in healthy life expectancy at birth);
- Indicator 3: Increase healthy life expectancy (Healthy life expectancy at birth);
- Indicator 4: Reduce preventable deaths (Preventable mortality); and
- Indicator 7: Improve health in pregnancy (The proportion of babies born at a low birth weight).

The delivery plan aligns with and enhances the strategic framework for public health Making Life Better, published in 2014, which was subject to separate screening

1.1.3 What is it trying to achieve? (intended aims/outcomes)

This delivery plan works towards the outcome “ we have long, healthy active lives” and will seek to contribute towards the delivery of indicators 2,3,4 and 7. The table below shows how these are all aligned with the Outcomes set out in the Draft Programme for Government Framework 2016-21.

https://www.northernireland.gov.uk/sites/default/files/consultations/newnigov/draft-pfg-framework-2016-21.pdf

Outcome	**Indicator**			
	2	**3**	**4**	**7**
3 - We have a more equal society	✓		✓	✓
4 - We enjoy long, healthy, active lives	✓	✓	✓	✓
6 – We have more people working in better jobs	✓	✓	✓	
8 - We care for others and we help those in need	✓	✓	✓	
13 – We connect people through our infrastructure	✓	✓	✓	
14 - We give our children and young people the best start in life	✓	✓		✓

The delivery plan is underpinned by a series of commitments to act by various delivery partners. Details on these are set out in Table 4 of the delivery plan.

1.1.4 If there are any Section 75 categories which might be expected to benefit from the intended policy, please explain how.

Implementation of the delivery plan should lead to improvements in health for the population as a whole.

A social gradient approach will be adopted which requires universal action but implemented with a scale and intensity proportionate to the level of social and health needs.

Benefits should therefore be universal, but with greater impact on those groups at risk of poorer health ie the most disadvantaged and vulnerable in society who experience the worst health.

In terms of the Section 75 categories the groups most likely to be affected are those with disabilities or long term conditions, ethnic minorities, LGB&T, men and women. It will also be relevant for all age groups including children and families, and older people.

1.1.5 Who initiated or wrote the policy?

Department of Health, Health Development Policy Branch with contributions from other Executive departments and in consultation with key stakeholders.

1.1.6 Who owns and who implements the policy?

The Programme for Government Indicators are set and monitored by the NI Executive. This Delivery plan sits within the remit of the Department of Health although it links with a number of other delivery plans and will require work across departmental and organisational boundaries.

1.2 Implementation factors

Are there any factors which could contribute to/detract from the intended aim/outcome of the policy/decision? If yes, are they

Financial ☑

Legislative ☒

Other ☑

These are evolving plans. A number of actions may be dependent on additional funding being allocated or secured. Others may be at low or no cost.

Health and wellbeing outcomes are impacted by a broad range of factors at the individual, community and population level.

In countries with the best health and narrowest health inequities the evidence suggests this is “related to a long and sustained period of improvement in the lives people are able to lead – socially cohesive societies, increasingly affluent, with developed welfare states and high quality education and health services.” *(Review of social determinants and the health divide in the WHO European Region)

The impact of this delivery plan will also be impacted by actions which will contribute to other PFG outcomes, in particular “We have a more equal society.”

1.3 Main stakeholders affected

Who are the internal and external stakeholders (actual or potential) that the policy will impact upon?

Staff ☑

Service users ☑

Other public sector organisations ☑

Voluntary/community/trade unions ☑

Other, please specify: Members of the public, particularly those suffering from disadvantage or disenfranchised from society

1.4 Other policies with a bearing on this policy / decision. If any:

Policy	Owner(s) of the policy
This delivery plan will have a bearing across a range of policies. It is most closely associated with the Programme for Government, and will impact on, and be impacted by, a number of related delivery plans, however it will also have the potential to impact on the following policies, for example–	
Making Life Better	DoH - led
Other public health policies, eg in relation to Suicide Prevention, Tobacco, Obesity Prevention	DoH
Active Ageing Strategy	DfC
Child Poverty Strategy	DfC
Strategy to improve the lives of people with disabilities	DfC DfC

Maternity Strategy	DoH
Long term conditions Strategy	DoH
More broadly the delivery plan may have impacts across policies in relation to education, health, environmental and social matters It will also evolve to align with Health and Wellbeing 2026 – Delivering Together	

1.5 Available evidence

What evidence/information (both qualitative and quantitative*) have you gathered to inform this policy? Specify details for each of the Section 75 categories.

General

Indicators 2 and 3 focus on Healthy Life Expectancy which is a relatively new measure which suggests that although people are living longer, people still live many years in poor health. The measure is based on trend data collected through the annual Health Survey Northern Ireland (HSNI) and focuses on an individual's perception of their own health and the area in which they live. The sample size of the Health Survey is such that statistical analysis for Section 75 groups is only possible for gender.

It is, however, recognised that other measures illustrate a Section 75 dimension, for example, the All Ireland Traveller Health Survey 2010 reported poor life expectancy for Travellers compared to the rest of the population.

Indicator 4, preventable mortality – a death is considered preventable if, in the light of understanding of the determinants of health at the time of death, all or most deaths from that cause (subject to age limits if appropriate) could be avoided by public health interventions in the broadest sense. This includes various causes of death: Heart disease;

lung cancer; accidental injury; suicide; respiratory disease; alcohol related; colon cancer; breast cancer; throat cancer; transport collisions; and other causes.

There will be Section 75 aspects to some of these, for example, suicide rate is three times higher for males than females; breast cancer mainly affects females.

Indicator 7, health in pregnancy, will look at the proportion of all live births where the birth weight of the child was less than 2,500g as recorded on the Child Health System.

Again there will be Section 75 aspects, for example, the All Ireland Traveller Health Survey 2010 reported that for Travellers in Northern Ireland 4.5% (n=157) of births were less than 2500g compared with an ESRI 2007 national perinatal statistics figure of 3.7% (n=69,318).

In order to turn the curves on these indicators key actions and priorities have been brought together in a **Healthier Lives Programme** which will connect actions across a range of settings. The proposed delivery plan, has a number of elements which will be underpinned by a series of commitments to act by various delivery partners. Details are set out in Table 4 of the delivery plan.   Commitments include:-

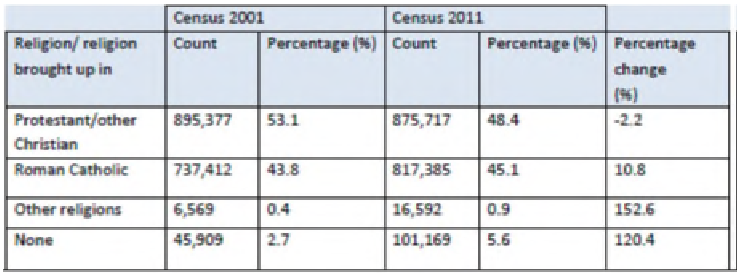
- Healthier Pregnancy programme ;
- Healthier Places programme in community settings;
- Healthier Lives programme for those with long-term conditions;
- Healthier Workplaces

And a wider programme -

- Increase first year training intake for GPs.
- Protect Life 2 and reduction in repeat self harm;
- Making Every Contact Count;
- Consideration of policy and legislation to enable Smoke free public spaces, new Public health legislation and Minimum Unit Pricing on Alcohol; and
- Development of better information and analysis on inequalities for HSC staff and organisations to inform priority setting and approaches.

The delivery plan will continue to evolve and be refined. Further assessment of equality implications will be made as individual actions/programmes are designed and taken forward.

The delivery plan will also be underpinned by the actions listed in para 4.4 which refers to collaboration with other departments. Equality implications of these will be considered by the lead partner.

<table>
<tr><th>Section 75 category</th><th>Details of evidence/information</th></tr>
<tr><td>Religious belief</td><td>
On Census Day 2011, the population of the north of Ireland was 1,810,863. 2011 census data indicates that 45.14% of all usual residents in NI gave their religion, or the religion they were brought up in as Catholic, and 48.36% as Protestant or other Christian. Other religions accounted for 0.92%, while 5.59% cited either having no religion or not having been brought up in a religion.
Source:
http://www.nisra.gov.uk/Census/key_report_2011.pdf
Table2: Changes in religious makeup of NorthernIreland between 2001 and 2011 censuses
(Source:NISRA,TableKS07b(2003);KS212(2012))

<table>
<tr><th></th><th colspan="2">Census 2001</th><th colspan="2">Census 2011</th><th></th></tr>
<tr><th>Religion/ religion brought up in</th><th>Count</th><th>Percentage (%)</th><th>Count</th><th>Percentage (%)</th><th>Percentage change (%)</th></tr>
<tr><td>Protestant/other Christian</td><td>895,377</td><td>53.1</td><td>875,717</td><td>48.4</td><td>-2.2</td></tr>
<tr><td>Roman Catholic</td><td>737,412</td><td>43.8</td><td>817,385</td><td>45.1</td><td>10.8</td></tr>
<tr><td>Other religions</td><td>6,569</td><td>0.4</td><td>16,592</td><td>0.9</td><td>152.6</td></tr>
<tr><td>None</td><td>45,909</td><td>2.7</td><td>101,169</td><td>5.6</td><td>120.4</td></tr>
</table>
There are marked differences between people in different social circumstances in terms of preventable deaths, Healthy Life Expectancy (HLE) and other health behaviours and outcomes. For example, in 2012-14, the
</td></tr>
</table>

gap in HLE between the most and least deprived quintiles stood at 12.2 years for males and 14.7 years for females.

The 2012 HSCIMS report “A Section 75 Analysis of Mortality Patterns in Northern Ireland
2003-200” found that –

- Apart from age, gender and Limiting long term illness (LLTI), social deprivation had a bigger effect on mortality and life expectancy than Section 75 characteristics.
- Those from a Catholic background had a slightly elevated ASMR and lower life expectancy.

https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/hscims-s75-amp-2003-07.pdf

Political opinion

There is limited data available. The following table shows the first preference votes cast in the 2016 NI Assembly elections (Electorate 1,281,595 turnout 54.2%).

Political Party	**Votes**
Democratic Unionist Party	202,567
Sinn Fein	166,785
Ulster Unionist Party	87,302
SDLP	83,364
Alliance Party	48,447
Green	18,718

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<tr>
<td></td>
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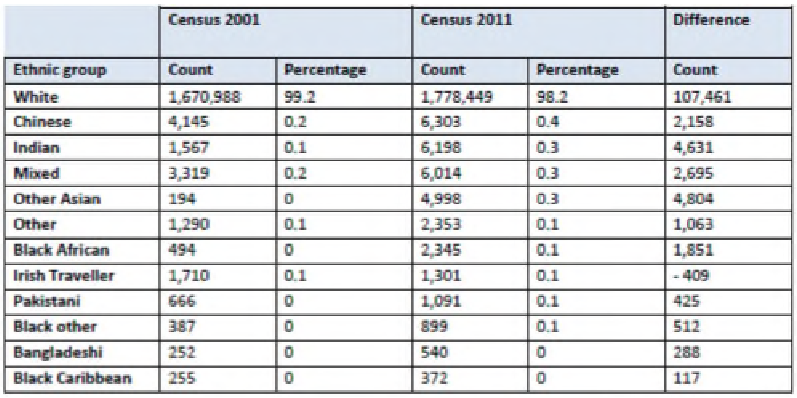
<table>
<tr><td>People before Profit Alliance</td><td>13,761</td></tr>
<tr><td>Traditional Unionist Voice</td><td>23,776</td></tr>
<tr><td>Independents</td><td>22,650</td></tr>
<tr><td>Others</td><td>26,940</td></tr>
</table>
Source: BBC website: http://www.bbc.co.uk/news/election/2016/northern_ireland/results
</td>
</tr>
<tr>
<td>Racial group</td>
<td>
Since the 2001Census, there has been a marked change in ethnic diversity in the north of Ireland. On Census Day 2011,1.8% (32,400) of the resident population belonged to minority ethnic groups, more than double the proportion in 2001 (0.8%). The main minority ethnic groups were Chinese (6,300 people) Indian (6,200), Mixed (6,000) and Other Asian (5,000), each accounting for around 0.3% of the population.



<table>
<tr><th></th><th>Census 2001</th><th></th><th>Census 2011</th><th></th><th>Difference</th></tr>
<tr><th>Ethnic group</th><th>Count</th><th>Percentage</th><th>Count</th><th>Percentage</th><th>Count</th></tr>
<tr><td>White</td><td>1,670,988</td><td>99.2</td><td>1,778,449</td><td>98.2</td><td>107,461</td></tr>
<tr><td>Chinese</td><td>4,145</td><td>0.2</td><td>6,303</td><td>0.4</td><td>2,158</td></tr>
<tr><td>Indian</td><td>1,567</td><td>0.1</td><td>6,198</td><td>0.3</td><td>4,631</td></tr>
<tr><td>Mixed</td><td>3,319</td><td>0.2</td><td>6,014</td><td>0.3</td><td>2,695</td></tr>
<tr><td>Other Asian</td><td>194</td><td>0</td><td>4,998</td><td>0.3</td><td>4,804</td></tr>
<tr><td>Other</td><td>1,290</td><td>0.1</td><td>2,353</td><td>0.1</td><td>1,063</td></tr>
<tr><td>Black African</td><td>494</td><td>0</td><td>2,345</td><td>0.1</td><td>1,851</td></tr>
<tr><td>Irish Traveller</td><td>1,710</td><td>0.1</td><td>1,301</td><td>0.1</td><td>- 409</td></tr>
<tr><td>Pakistani</td><td>666</td><td>0</td><td>1,091</td><td>0.1</td><td>425</td></tr>
<tr><td>Black other</td><td>387</td><td>0</td><td>899</td><td>0.1</td><td>512</td></tr>
<tr><td>Bangladeshi</td><td>252</td><td>0</td><td>540</td><td>0</td><td>288</td></tr>
<tr><td>Black Caribbean</td><td>255</td><td>0</td><td>372</td><td>0</td><td>117</td></tr>
</table>

Changes in ethnic make up of Northern Ireland between 2001and 2011 censuses (Source: NISRA,Table KS06 (2003); KS201(2012)

Language (spoken by those aged 3 and over):
</td>
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</table>

Ethnicity	**Number**	**(%)**
English	1,681,210	96.86%
Polish	17,704	1.02%
Lithuanian	6,249	0.36%
Irish (Gaelic)	4,166	0.24%
Portuguese	2,256	0.13%
Slovak	2,256	0.13%
Chinese	2,256	0.13%
Tagalog/Filipino	1,909	0.11%
Latvian	1,215	0.07%
Russian	1,215	0.07%
Hungarian	1,041	0.06%
Other	13,018	0.75%

It is recognised that some Black and Minority Ethnic persons can face barriers e.g. language in relation to accessing services and that at times additional support is needed. The number of requests received by the NI HSC Interpreting Service has risen from 10,257 in 2005/6 to over 97,800 in 2015/16.

The most recent top ten language requests were for: Polish, Lithuanian, Romanian, Portuguese, Chinese (mandarin), Tetum, Slovak, Hungarian, Bulgarian, and Chinese (Cantonese).

Source: NIHSCIS

The All Ireland Traveller Survey (AITHS) 2010[i] estimates there were 3905 Irish Travellers in the north of Ireland.

AITHS 2010 provides evidence of a poorer health profile than the general population – travellers of all ages have much higher mortality rates with differentials in life expectancy averaging 11 years less than the general population.

Overall mortality is 3.5 times higher than in the general population for both genders (males 3.7; females 3.1). Infant mortality is approximately three and a half times that in the general population.

Life Expectancy figures for different ethnic groups is not available for the North of Ireland, however some studies suggest differences in life expectancy rates between ethnic minority groups.

http://jech.bmj.com/content/early/2016/07/29/jech-2016-207426.full

There is some evidence that some ethnic minority groups are more likely to die early from certain causes.

http://www.parliament.uk/documents/post/postpn276.pdf

In the last decade, similar to England, Scotland and Wales, the increase in inward migration has resulted in the number of births to non-UK and non-Republic of Ireland (ROI) born mothers increasing. In 2012, 1 in 10

	births were to non-UK and ROI born women National reports and research[1] have indicated that women from certain migrant and minority ethnic groups, including Irish Travellers, are more likely to have maternal ill health and be at higher risk of poorer pregnancy outcomes. The Centre for Maternal and Child Enquiries (CMACE) reports on maternal and perinatal deaths in the UK have consistently shown that outcomes in pregnancy are worse in minority ethnic women than in white women.[2] 1Northern Ireland Statistics and Research Agency. Register General Northern Ireland Ninetieth Annual Report 2011. NISRA, 2012. Department of Health, Social Services and Public Safety. A strategy for maternity care in Northern Ireland 2012-2018. Belfast: DHSSPSNI, July 2012. Institute of Applied Social Sciences, University of Birmingham. Delivering in an age of super-diversity: West Midlands review of maternity services for Migrant women. Birmingham: 2010. [2]Centre for Maternal and Child Enquiries (CMACE). Saving Mother's Lives: reviewing maternal deaths to make motherhood safer (the 6th, 7th and 8th reports on confidential enquiries into maternal deaths in the United Kingdom). London: CMACE; 2000- 2002; 2003-2005 and 2006- 2008 http://www.hqip.org.uk/cmace-reports/
Age	The age profile of the population is expected to gradually become older. Over the ten year period between 2003 and 2013, the number of adults here aged 65 and over increased by 22%. The trend is expected to continue with the proportion of the population in this age group projected to increase by 63% to just under half a million people by 2033. An ageing population is a significant achievement, reflecting advances in health and quality of life. A key challenge will be to enable older people to remain in good health for as long as possible.

Age and gender are the two main predictors for determining mortality.

According to the 2014/15 Health Survey Northern Ireland (HSNI) 72% of adults describe their health as good or very good. A decline in general health rating was observed with increased age, with respondents 75years and over more than 4 times as likely to report bad or very bad health(13%) compared with those in 16-24 age group (3%).

Around a third (31%) of respondents in most deprived areas were very satisfied with life compared to almost a half in the least deprived.

Disability prevalence increases with age. The proportion of respondents indicating they have a long-standing illness increased with age, from 15% of 16-24 year olds to 67% of those aged 75 and over. Long term conditions have a major impact on healthy life expectancy and on the rate of preventable deaths.

Some examples of other key statistics and issues on health and influencing factors for each lifestage include –

- poverty is the greatest risk factor for health. There are high levels of child deprivation - 25% of children in NI live in relative income poverty (2014/15);

- high levels of fuel poverty - cold damp housing can cause respiratory or cardiovascular diseases and for example may contribute to additional winter deaths among older people;

- 28% of children were assessed as either overweight (21%) or obese (7%)

- 60% of adults measured for the Health survey 2014/15 were either overweight (35%) or obese (25%)

	- smoking prevalence declined with age from over a quarter (26%) of 16-24 year olds currently smoking to 7% of those aged 75 years and over
Marital status	The 2011 census has found that 47.56% of all usual residents aged 16 or over are ‘married’. 36.14% as single (defined as never married or registered in a same sex civil partnership) and 9.43% as either separated or divorced. 0.09% are in a registered same-sex partnership. The 2012 HSCIMS report “A Section 75 Analysis of Mortality Patterns in Northern Ireland 2003-2007” found that: • Life expectancy (LE) among married men and women (aged 16+) was on average two years higher than the respective overall life expectancy for males and females. • Life expectancy was 6 years lower among widowers and 3 years lower among widows than for married males and females. • Divorcees have lower life expectancy on average than those who are married and this effect was more pronounced among men. • Those who were married or co-habiting experienced lowest ASMRs and highest life expectancy.
Sexual orientation	Accurate figures are not available on the sexual orientation of the general population, and estimates vary considerably. The Northern Ireland Statistics and Research Agency (NISRA), along with other UK census offices, concluded that the census was not suitable for obtaining such information. The 2011 Census does provide some information, based on same-sex civil

partnerships.

Research by HM Treasury shows that from 5%–7% of the UK population say they are gay, lesbian, bisexual or ´trans´ (transsexual, transgendered and transvestites).

The 2010 Northern Ireland Life and Times survey (1,205 adults) reported the figure as only 1%. The Office for National Statistics 2010 report (450,000 respondents) found that in Northern Ireland 92.5% said they were heterosexual and 0.9% of respondents said they were LGBT, although 0.4% reported as 'other' and 6.2% said they didn't know or refused to respond.

The 2012/13 Health Survey from the DHSSPS(NI) Information Analysis Directorate provided the following population split 93% Heterosexual/Straight; 1% Gay/Lesbian; 2% Bisexual; 1% Other; and, 3% Not specified.

LGBT people can have specific needs/ experiences/ priorities in relation to service provision, economic/ workplace inclusion, education, health and well-being and community safety and security.

To date very little general LGBT health research has been published in the north of Ireland however research in England on LGBT experience of healthcare suggests numerous barriers including homophobia and heterosexism, misunderstandings and lack of knowledge and lack of protocols. Ref: Section 75 Equality Action Plan 2013-2018 PHA

Reports such as Rainbow's project "Through our Minds" 2013 highlight key issues for LGBT people in relation to health and wellbeing outcomes, including higher risk of mental disorder, for example - 35.3 % of respondents in the north of Ireland has experienced self harm; 25.7% had experienced a suicide attempt; 46.9% had

	experienced suicidal ideation and 70.9% had experienced depression. Screening has confirmed higher levels of STIs amongst key sections of the LGBT community
Gender (Men and women generally)	In the north of Ireland 49% of the population are male and 51% are female. Age and gender are the two main predictors for determining mortality Life expectancy between 1981 and 2010 increased steadily for both males and females by 8 and 6 years respectively. Female life expectancy has consistently been higher than that for males however as male life expectancy has grown at a faster rate since 1981, the gender gap has declined. More recently this gap has decreased by 0.3 years since 2007-09 and is currently 4.3 years. The influence of social conditions and lifestyle behaviours is evident when comparing life expectancy and healthy life expectancy for men and women across geographic areas – for example Male life expectancy was 7.5 years lower in the most than least deprived areas. For females the equivalent gap is 4.3 years. Female Healthy Life Expectancy in the most deprived areas was 14.2 years lower than in the least deprived, while this gap was 11.8 years for males.
Disability (with or without)	Limiting long-standing illness, proxy measure for disability, is collected via the annual NI Health Survey. In 2014/15, 29% of respondents stated that they had a Limiting Long-standing Illness. Two fifths (39%) of

	males and females in the most deprived areas stated they had a limiting long-standing illness compared with 23% in the least deprived areas. Male disability – free Life Expectancy in the most deprived areas of NI was12.0 years lower than in the least deprived areas, the gap for females was 12.9 years. https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/hscims-2015-key-facts.pdf People with disabilities face a range of challenges and have a variety of needs, for example availability of accessible information, communication issues, physical limitations. Many people who live with long term conditions – including physical illness, disability and chronic pain – will at some time experience periods of depression that may be undiagnosed and untreated. It is widely recognised that disability increases with age and therefore the demand on services will grow significantly in the next decade and beyond. Although people are living longer, there is the prospect that they will experience more years of ill-health, and that more will need help with everyday activities.
Dependants (with or without)	At the time of the 2011 Census the total number of households was 703275 of which 238272 households contain dependent children. The number of dependent children in households was 439,896. In 2013-14, on the After Housing Costs (AHC) measure single parents had the highest proportion living in relative poverty, at 38%. For comparison the proportion of single adults without children living in relative poverty

	was 27%. Larger families are generally more likely to be in poverty than smaller families. In 2013-14 children living in families with three or more children were most likely to be in relative poverty at 31% BHC and 32% AHC. The proportion of babies born at a low birth weight has remained unchanged over the last 6 years with 6.1% of babies weighing under 2,500g at birth in 2011-2014. Census respondents were asked whether they provide any unpaid help or support to family members, friends, neighbours or others because of long-term physical or mental ill-health / disabilities, or problems related to old age. Twelve per cent of the population (213,980) provided such unpaid care, around a quarter (26 per cent) of whom did so for 50 or more hours per week, a total of 56,000 persons. *The term 'care' covers any unpaid help, looking after or supporting family members, friends, neighbours or others because of long-term physical or mental ill-health or disability or problems related to old age.

***** Qualitative data – refers to the experiences of individuals related in their own terms, and based on their own experiences and attitudes. Qualitative data is often used to complement quantitative data to determine why policies are successful or unsuccessful and the reasons for this.

Quantitative data - refers to numbers (that is, quantities), typically derived from either a population in general or samples of that population. This information is often analysed either using descriptive statistics (which summarise patterns), or inferential statistics (which are used to infer from a sample about the wider population).

1.6 Needs, experiences and priorities

Taking into account the information recorded in 1.1 to 1.5, what are the different needs, experiences and priorities of each of the following categories, in relation to the particular policy/decision? Specify details for each of the Section 75 categories

General

The evidence on reducing inequalities in health[1] is that actions are needed that are universal, but implemented with a scale and intensity proportionate to the level of social and health needs (proportionate universalism).

All aspects of the delivery plan should have positive impacts to all sections of the population who avail of them. While some needs exist for certain groups these will be identified and addressed in the development and design of the "Commitments to act" set out in table 4 of the Delivery Plan.

[1] eg Fair Society, Healthy Lives, The Marmot Review, Strategic Review of Health Inequalities in England post - 2010

Section 75 category	Details of needs/experiences/priorities
Religious belief	No evidence of specific needs has been identifed
Political opinion	No evidence of specific needs has been identified
Racial group	Different migrant groups bring different challenges in relation to issues of health protection (Tb, Hep B, Hep C, HIV), vulnerability to non-communicable diseases, experience of health care (immunisation, prevention, screening, treatment), cultural beliefs about health/illness and acceptability of treatments. Experiences from country of origin (eg conflict, war, torture) have lasting impact. Many migrants experience discrimination and are disadvantaged in relation to the wider determinants of health. The report Barriers to health: migrant health and wellbeing in

	Belfast, prepared by the Belfast Health Development Unit (BHDU, 2011), provided a general summary on the health status and needs of ME groups and the wider determinants of health such as legislation around immigration and work, entitlement to social security benefits and health and social care, work, housing, education, etc. Mental health is an important issue for many ME groups - social isolation can lead to loneliness and depression as well as to excessive alcohol consumption. Women from certain migrant and minority ethnic groups, including Irish Travellers, are more likely to have maternal ill health and be at higher risk of poorer pregnancy outcomes. The emphasis within the delivery plan on supporting and empowering individuals, families and communities to maintain their own health should benefit all, including those from ME groups
Age	Health is impacted by the cumulative effects of the conditions in which people are born, grow, live, work and age. There are changing needs at different lifestages. Evidence demonstrates that much of the incidence of premature death or illness is preventable, and that action to reduce health inequalities must start before birth and be followed through the life of the child if the close links between early disadvantage and poor outcomes throughout life are to be broken. From pregnancy through early childhood all of the environments in which children live and learn and the quality of their relationships with adults and care givers, have a significant impact on their cognitive, emotional, social and physical development, and lays the foundations for outcomes in later life. Children living in poverty are more at risk of physical and mental ill health and an accumulation of health risks. Youth is generally a time of peak health, however it is often associated with risk taking behaviour.

Growing up is a time of considerable health needs - schools are vitally important settings for personal and social development and the development of life skills and behaviours which will influence later life chances.

Many older people enjoy good health and continue to contribute to society, however for too many older age brings a high risk of limiting illness, social isolation and poverty with limited access to services.

With a growing elderly population, research has identified that older people with mental health problems are an ever increasing group of people who are often isolated and marginalised from the local community.

Health expenditure increases with age so enabling those in later years to live as full and healthy a life as possible is a priority for them and for society.

Each of life’s transitions can affect health by moving people onto a more or less advantaged path; however people who have been disadvantaged in the past are at greater risk. Disadvantages tend to congregate among the same people and their effects accumulate through life and are passed on from generation to generation.

In support of this Hertzman and Power 2004 outline three health effects that have relevance for a life-course perspective.

Latent effects are biological or developmental early life experiences that influence health later in life. Low birth weight, for instance, is a reliable predictor of incidence of cardiovascular disease and adult-onset diabetes in later life. Experience of nutritional deprivation during childhood has lasting health effects.

Pathway effects are experiences that set individuals onto trajectories that influence health, well-being, and competence over the life course. As one example, children who enter school with delayed vocabulary are set upon a path that leads to lower educational expectations, poor employment prospects, and

	greater likelihood of illness and disease across the lifespan. Deprivation associated with poor-quality neighbourhoods, schools, and housing sets children off on paths that are not conducive to health and well-being. Cumulative effects are the accumulation of advantage or disadvantage over time that manifests itself in poor health. These involve the combination of latent and pathways effects. Adopting a life-course perspective directs attention to how social determinants of health operate at every level of development—early childhood, childhood, adolescence, adulthood and later life—to both immediately influence health and provide the basis for health or illness later in life. Refs: http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review “A life course approach to Health and Human Development”, Clyde Hertzman and Chris Power 2004 The delivery plan will adopt a lifecourse approach, with elements focussed on lifestages and settings– eg health in pregnancy, healthier workplaces, age themes within healthier places element
Marital status	There are many studies which consider the association between marital status and psychological wellbeing. Generally it is considered that partnered living (married or cohabiting) is associated with higher psychological well-being than being single. Sociologists, psychologists and epidemiologists have recently documented evidence of married people’s better physical health, longevity, psychological health, and reported happiness. Married individuals fare better in these terms than the never married, who in turn do better than the divorced, separated and widowed. (C.M Wilson. A.J Oswald, and European Sociological Review)

Sexual orientation

Research has shown that LGBT people are at significantly higher risk of mental disorder with higher rates of anxiety, depression, self harm and suicidal behaviour as well as higher problem drug and alcohol use. (Rainbow Project's Through Our Minds Report 2013, and Through our Eyes (2011): Experiences of Lesbian, Gay and Bisexual people in the Workplace; Lifestyle and Coping Survey 2010.)

Mental health issues often relate to homophobia (including internalised homophobia) having a profound effect on self esteem, discrimination, family rejection and isolation.

Reviews have also indicated that LGBT people experience significant barriers to accessing health services eg service providers assume their needs are similar to those of heterosexual men and women.

Ref:PHA (2011): Health Intelligence briefing on LGBT health related issues

The emphasis within the delivery plan on supporting and empowering individuals, families and communities to maintain their own health should benefit all, including LGBT people

Gender (Men and women generally)

Men and women are prone to different types of diseases at different ages, and there are different prevalences of health behaviours –

The Table below details the main causes of preventable mortality in 2010-14. For men, these were Heart Disease (25.3%) and cancer of the lung and airways (15.9%). For women, the main causes were cancer of the lung and airways (18.1%) and breast cancer (14.3%). [extract from delivery plan.]

Table – Causes of Preventable Deaths in NI

Cause of Death	**Applicable Ages**	**Male**	**Female**	**All**
Total		**10,028**	**6,085**	**16,113**
4.1 Heart Disease	0-74	2,535	837	3,372

4.2 Lung cancer	0-74	1,597	1,102	2,699
4.3 Accidental Injury	All	960	792	1,752
4.4 Suicide	All	1,106	344	1,450
4.5 Respiratory Disease	0-74	576	548	1,124
4.6 Alcohol related	0-74	721	331	1,052
4.7 Colon Cancer	0-74	608	391	999
4.8 Breast Cancer	0-74	5	871	876
4.9 Throat Cancer	0-74	355	121	476
4.10Transport collisions	All	329	104	433
4.11Other causes	All	1236	644	1880

The main preventable causes of premature death are known to be smoking, alcohol misuse, poor diet, lack of physical activity and being overweight/ obese. In respect of these -

- Smoking prevalence – 23% of males and 21% of females (2014/5 Health survey)

- 21% of males drank above the new CMO weekly guidelines compared with 8% of females

- Males (66%) were more likely than females (56%)to be overweight or obese

- 60% of males meet the CMO physical activity guidelines compared with 47% of females

In respect of mental health-

-females were more likely to show signs of a possible mental health problem (20% and 16%)

-young males in deprived areas are particularly vulnerable, as are marginalised groups such as those who are unemployed, or people with mental illness and addiction problems.

(Further information is included in the results of the 2014/15 Health Survey Northern Ireland, and through the reports of the NI Health and Social Care Inequalities Monitoring system, and in specific underpinning Health Promotion strategies and frameworks, eg Obesity Prevention framework – A Fitter Future for

	All, Tobacco Strategy, etc.)
Disability (with or without)	In general, statistics and other surveys show that on most indicators of social and economic wellbeing, such as labour market, income and educational attainment, people with disabilities continue to be among the most disadvantaged groups in society. They are likely to be less well qualified, much less likely to be economically active and therefore in employment, much more likely to be in poverty, much less likely to enjoy an active social life and much more likely to suffer poor health including poor mental health. Evidence such as “Health Inequalities and People with Learning Disability in the UK” (E. Emerson & S. Baines, 2010) showed that people with a learning disability on average had a higher rate of poor ill health and of mortality than their non-learning disabled peers. They are more likely to experience major illnesses, to develop them younger and die of them sooner than the population as a whole. Persons with disabilities can face specific barriers in relation to participation and active citizenship; discrimination; accessibility to the physical environment, goods and services and mobility; housing, care, social activities and transport; employment and employability.
Dependants (with or without)	A wide range of research evidence from education, health, justice, and economic experts supports the view that what happens to children in their earliest years is key to outcomes in adult life. Research also shows that a shift in emphasis towards co-ordinated support in early years is the most likely route to breaking the cycle of disadvantage and reducing inequalities in health. Good maternal health during pregnancy is vital for both the mother and child. Low birth weight (LBW) babies are at increased risk for developing mental problems related to physical

	health, psychological adjustment and intellectual functioning. Risk factors in the mother that may contribute to low birth weight include young age, multiple pregnancies, previous LBW infants, poor nutrition, heart disease or hypertension, drug addiction, alcohol abuse and insufficient prenatal care. Research by McAvoy et al in 2006 has shown that babies born to parents who were unemployed were approximately twice as likely to have a low birth weight as those born to parents who belonged to professional occupational groups, and those born to teenage mothers were also significantly more likely to have a low birth weight. This research also highlighted the lasting causal effects of low birth weight has on later life, including a greater risk of death, disability and academic underachievement. There is a substantial body of literature highlighting the benefits of early engagement with structured childcare and with parenting programmes. Individuals and communities benefit from the strong attachment and emotional links that are created by good parenting and early life experiences. Supporting parents to develop effective parenting skills has therefore been recognised as a significant prevention and intervention strategy, providing the foundation for realising the potential of children and young people, and for longer term public health and wellbeing. Continuity in children's early experiences from home to pre-school and on through school is also important. Carers often neglect their own physical and mental wellbeing and are more likely to experience high levels of psychological distress, including anxiety, depression and loss of confidence and self esteem than non-carers. The delivery plan will adopt a lifecourse approach, with elements focussed on lifestages and settings– eg health in pregnancy, and, age themes within healthier places element. The places/community element will also include improving mental

	health and wellbeing

Part 2. Screening questions

All aspects of the Delivery Plan should have positive impacts to all sections of the population who avail of them. While some needs exist for certain groups these will be identified and addressed via the development of the "Commitments to act" set out in table 4 of the Delivery Plan.

For example, Protect Life 2 will be of positive benefit for all but in particular certain groups such as: young men; gay men; and, those with mental health problems.

2.1 What is the likely impact on equality of opportunity for those affected by this policy, for each of the Section 75 equality categories? (minor/major/none)		
Section 75 category	Details of policy impact	Level of impact? minor/major/none
Religious belief	There is no expectation of a negative policy impact on people of differing religious beliefs.	None.
Political opinion	We are not aware of particular impacts in relation to political opinion.	None.
Racial group	All aspects of the delivery plan should have positive impacts and address inequalities. It is not envisaged that there will be adverse impact in respect of people of different racial or ethnic backgrounds.	None.

Age	In line with international evidence the plan takes a lifecourse approach and will have positive impacts across all age groups.	None.
Marital status	There is no expectation of a negative policy impact on people of differing marital status.	None.
Sexual orientation	All aspects of the delivery plan should have positive impacts and address inequalities. It is not envisaged that there will be adverse impact in terms of sexual orientation.	None.
Gender (Men and women generally)	All aspects of the delivery plan should have positive impacts and address inequalities; it is not envisaged that there will be adverse impact in terms of gender.	None.
Disability (with or without)	All aspects of the delivery plan should have positive impact and address inequalities; it is not envisaged that there will be adverse impact in relation to those who have a disability/disabilities	None.
Dependants (with or without)	All aspects of the delivery plan should have positive impact and address inequalities; it is not envisaged that there will be adverse	None.

	impact in terms of dependants.	

2.2 Are there opportunities to better promote equality of opportunity for people within the Section 75 equalities categories?		
Section 75 category	If **Yes**, provide details	If **No**, provide reasons
Religious belief	As the delivery plan focuses on improving health and reducing inequalities, the actions have the potential to ensure increased opportunities for everyone to be empowered and supported to lead healthy lives. The social gradient approach requires universal action but implemented with a scale and intensity proportionate to the level of social and health needs. Benefits should therefore be universal, but with greater positive impact on those groups at risk of poorer health ie the most disadvantaged and vulnerable who experience the worst health.	
Political opinion	As above.	
Racial group	As above.	

Age	As above.	
Marital status	As above.	
Sexual orientation	As above.	
Gender (Men and women generally)	As above.	
Disability (with or without)	As above.	
Dependants (with or without)	As above.	

2.3 To what extent is the policy likely to impact on good relations between people of different religious belief, political opinion or racial group? (minor/major/none)		
Good relations category	Details of policy impact	Level of impact minor/major/none
Religious belief	The plan relies on collaborative working and that includes with communities. The communities and social networks to which people belong have a significant impact on health and wellbeing – support from families, friends and communities is associated with better health, and social capital can promote resilience against difficulties.	Indirect positive impact
Political opinion	As above	
Racial group	As above	

2.4 Are there opportunities to better promote good relations between people of different religious belief, political opinion or racial group?		
Good relations category	If **Yes**, provide details	If **No**, provide reasons

Religious belief		The delivery plan offers limited potential to better promote good relations.
Political opinion		The delivery plan offers limited potential to better promote good relations.
Racial group		The delivery plan offers limited potential to better promote good relations.

2.5 Additional considerations

Multiple identity

Provide details of data on the impact of the policy on people with multiple identities (e.g. minority ethnic people with a disability, women with a disability, young protestant men, young lesbian, gay or bisexual persons). Specify relevant Section 75 categories concerned.

Having multiple identities can result in different needs and impacts. For example in relation to suicide the needs of young, gay men, or in relation to life expectancy Traveller men. It is, therefore, recognised that -some multiple identity groupings will have specific experiences that need to be addressed within strategies and service provision. It is essential that service providers are aware that people often fit into more than one social category and therefore have multiple and complex needs to be taken into account.

The approach advocated by the delivery plan is that account must be taken of the need for greater intensity of action for those with greater social, economic and health disadvantage, therefore there should be positive impact on those with multiple identities.

2.6 Was the original policy / decision changed in any way to address any adverse impacts identified either through the screening process or from consultation feedback. If so please provide details.

No adverse impacts have been identified in relation to the Delivery Plan. Development to date has been informed by engagement with key stakeholders and partners and this will continue. Feedback of those representing Section 75 groups will be taken into account on an ongoing basis as actions are developed and progressed.

Part 3. Screening decision

3.1 How would you summarise the impact of the policy / decision?

No impact ☑

Minor impact ☐ Consider mitigation (3.4 – 3.5)

Major impact ☐

3.2 Do you consider that this policy / decision needs to be subjected to a full Equality Impact Assessment (EQIA)?

Yes - screened in ☐

No - screened out ☑

3.3 Please explain your reason for making your decision at 3.2.

No adverse differential impacts have been identified in relation to any of the Section 75 groups and on the basis that the delivery plan is intended to address health inequality, increase healthy life expectancy, reduce preventable deaths and improve health in pregnancy, and operates on the basis of objective need, it is judged that the equality impact of the plan will be largely positive.

We are therefore not proposing to screen the delivery plan in and conduct a full equality impact assessment at this stage.

Additionally the outcomes and indicators which the delivery plan is intended to deliver are part of the Programme for Government and have therefore been subject to a full consultation process.

Continued liaison with stakeholders will be part of this work and we will seek to respond to needs identified on an ongoing basis. Forthcoming public consultation will provide an opportunity to further review equality issues and amend the screening template as required.

Further assessment of equality implications will be made as individual actions in the plan are taken forward. Decisions on targeted action must be taken at a delivery level and take account of identified need.

Mitigation

If you have concluded at 3.1 and 3.2 that the likely impact is ‘**minor**’ and an equality impact assessment is not to be conducted, you must consider mitigation (or scope for further mitigation if some is already included as per 2.6) to lessen the severity of any equality impact, or the introduction of an alternative policy to better promote equality of opportunity or good relations.

3.4 Can the policy/decision be amended or changed or an alternative policy introduced to better promote equality of opportunity and/or good relations?

Yes ☐

No ☐

3.5 If you responded “**Yes**”, please give the **reasons** to support your decision, together with the proposed changes/amendments or alternative policy.

Part 4. Monitoring

Monitoring is an important part of policy development and implementation. Through monitoring it is possible to assess the impacts of the policy / decision both beneficial and adverse.

4.1 Please detail how you will monitor the effect of the policy / decision?

Actions taken forward will be monitored, reviewed and evaluated by the lead partner (DOH) using an Outcomes Based Accountability type approach. In addition progress against the indicators and outcome will be reported as appropriate. We will work with key stakeholders – such as the Centre of Excellence for Public Health at QUB – to ensure any plans for evaluation are robust, built in from the outset, and tap into wider research programmes to seek value for money and ensure translational learning.

This delivery plan will remain a live document, and actions will be reviewed, replaced and updated as we learn about their effectiveness. This learning will be fed directly into the ongoing delivery process.

4.2 What data will you collect in the future in order to monitor the effect of the policy / decision?

Data in relation to the four indicators will be collected on an ongoing basis. It is possible that a sub-set of indicators will also be agreed to help inform progress (for example indicators of the main factors associated with preventable death which also impact on healthy life expectancy.) OBA methodology will also ensure data is collected for example at service levels.

Low birth weight is a proxy measure for health in pregnancy which does not take account of specific growth charts or gestational age. Customised growth charts provide a more sensitive measure of a baby’s potential growth by taking account of maternal and paternal features which may affect the baby’s weight at birth. Health and Social Care Trusts have now begun collecting data on this measure, which once assessed may be a more effective and evidence based measure moving forward.

Additional data sets and systems may also assist in monitoring the effects, for example service usage, surveys etc.

Please note: - For the purposes of the annual progress report to the Equality Commission you may later be asked about the monitoring you have done in relation to this policy and whether that has identified any Equality issues.

Part 5. Disability Duties

5.1 Does the policy/decision in any way promote positive attitudes towards disabled people and/or encourage their participation in public life?

Whilst not specifically related to positive attitudes towards disabled people or participation in public life, the policy sets out actions that will pursue health equity and a reduction in health inequalities. This includes advocating for action across the whole social gradient, but with greater intensity of action towards those who are at the bottom of the gradient and those who are most vulnerable. Disabled people should benefit from all of the plan's elements, however one in particular is focussed on improving outcomes for people living with long term conditions and aims to reorient services to better support people to manage their own health

5.2 Is there an opportunity to better promote positive attitudes towards disabled people or encourage their participation in public life by making changes to the policy/decision or introducing additional measures?

Opportunities may exist during the process of design and progress of the actions to introduce additional measures

Part 6. Human Rights

6.1 Please complete the table below to indicate whether the policy / decision affects anyone's Human Rights?

ARTICLE	POSITIVE IMPACT	NEGATIVE IMPACT = human right interfered with or restricted	NEUTRAL IMPACT
Article 2 – Right to life			X

Article 3 – Right to freedom from torture, inhuman or degrading treatment or punishment			X
Article 4 – Right to freedom from slavery, servitude & forced or compulsory labour			X
Article 5 – Right to liberty & security of person			X
Article 6 – Right to a fair & public trial within a reasonable time			X
Article 7 – Right to freedom from retrospective criminal law & no punishment without law.			X
Article 8 – Right to respect for private & family life, home and correspondence.			X
Article 9 – Right to freedom of thought, conscience & religion			X
Article 10 – Right to freedom of expression			X
Article 11 – Right to freedom of assembly & association			X
Article 12 – Right to marry & found a family			X
Article 14 – Prohibition of discrimination in the enjoyment of the convention rights			X
1st protocol Article 1 – Right to a peaceful			X

enjoyment of possessions & protection of property			
1st protocol Article 2 – Right of access to education			X

6.2 If you have identified a likely negative impact who is affected and how?

how?

No negative impact identified.

At this stage we would recommend that you consult with your line manager to determine whether to seek legal advice and to refer to Human Rights Guidance to consider:

- *whether there is a law which allows you to interfere with or restrict rights*
- *whether this interference or restriction is necessary and proportionate*
- *what action would be required to reduce the level of interference or restriction in order to comply with the Human Rights Act (1998).*

6.3 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/decision.

None

This is a delivery plan which aligns with and enhances the public health framework Making Life Better. The promotion of health as a fundamental human right is amongst the values and principles adopted by the framework to guide action.

Part 7 - Approval and authorisation

	Name	**Grade**	**Date**
Screened completed by	Stephanie Tallentire	DP	14th October 2016
Approved by[1]	Gary Maxwell	Gde 7	14th October 2016
Forwarded to E&HR Unit[2]			

Notes:

[1] The Screening Template should be approved by a senior manager responsible for the policy this would normally be at least Grade 7.

[2] When the Equality and Human Rights Unit receive a copy of the final screening it will be placed on the Department's website and will be accessible to the public from that point on.   In addition, consultees who elect to receive it, will be issued with a quarterly listing all screenings completed during each three month period.