Preparing for the Health and Social Care Trust's Equality Action Plans

Audit of Inequalities

Section 75 Equality Groups

November 2010

CONTENTS

BACKGROUND

Section 75 of the Northern Ireland Act 1998 requires the all health and social care (HSC) trusts, when carrying out their work, to have due regard to the need to promote equality of opportunity between nine categories of persons, namely:

- between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation;
- between men and women generally;
- between persons with a disability and persons without; and
- between persons with dependants and persons without.

Trusts must also have regard to the desirability of promoting good relations between persons of different religious belief, political opinion or racial group.

Whilst much good work has been achieved over the last decade in promoting equality of opportunity and good relations, there still remain persistent inequalities within our society. The Equality Commission Northern Ireland (ECNI) revised 'Guide to the S75 Statutory Duties for Public Authorities' emphasised the need for public authorities to shift from 'process to outcomes'. Whilst the review found that whilst public authorities had worked hard to follow due process and develop transparent policy development processes, the review found that there was still a lot to be done to ensure that the statutory duties have a positive impact on people's lives.

The Equality Commission Northern Ireland (ECNI) revised 'Guide to the S75 Statutory Duties for Public Authorities' details a number of new recommendations from the Commission's Section 75 Effectiveness Review. Public authorities must develop a new/revised Equality Scheme and in addition to carry out an audit of inequalities and produce an associated action plan.

"An audit of inequalities is a systematic review and analysis of inequalities which exist for service users and those affected by P.A. policies in order to inform the P.A. work in relation to the promotion of S75 equality and good relations duties." (ECNI 2010)

An audit of inequalities is intended to inform the development of action-based plans and set the framework for the Trusts to address inequalities relevant to their functions. The audit should enabled the Trusts to identify potential functional areas for further or better discharge of the Section 75 duties and inform key strategic actions.

The purpose of this report is to detail on how the Trusts carried out their audit of inequalities.

FUNCTIONS OF HEALTH AND SOCIAL CARE TRUSTS

The six Health and Social Care Trusts came into operation on 1 April 2007. Five Health and Social Care Trusts provide integrated health and social care services across Northern Ireland: Belfast HSC Trust, South Eastern HSC Trust, Western HSC Trust, Southern HSC Trust and Northern HSC Trust. The sixth Trust is the Northern Ireland Ambulance Service HSC Trust. It operates a single Northern Ireland wide service to people in need and aims to improve the health and well-being of the community through the delivery of high quality ambulance services.

The Health and Personal Social Services (Northern Ireland) Order 1991 Article 10(1) defines the nature and function of the Trusts as a major employer and provider of health and social care services.

The Trusts provide a wide range of hospital, community and primary care services. Delivering safe and effective services which are accessible and responsive to the needs of patients, clients and carers is central to the role of Trusts. Trusts also purchase some services from the independent and community/voluntary sectors.

Trusts also have the power to exercise statutory functions which embrace all the activities undertaken by the Trust including the recruitment/employment of its staff, financial arrangements, contracted-out services and staff training, maintenance of its property and the delivery and development of services, including the purchase of equipment and facilities needed to do this.

The Trusts carry out their business in the following ways:

- undertake assessments of needs
- developing strategies to address those needs
- setting and monitoring quality and performance standards
- carrying out reviews of service areas
- resource allocation and financial management
- setting service agreements with purchasers of care
- human resource management in relation to its staff, and
- corporate and clinical governance, i.e. ensuring safe practices.

The main decision making bodies in the Trusts are the Trust Boards and Senior/Executive Management Teams. The Trusts each have a Chief Executive and a Chairman. The Chief Executive is the accountable officer for the Trust. The Chairman works very closely with the Chief Executive and is responsible for the operation of the Trust Board.

COMPLETION OF AUDIT OF INEQUALITIES - METHODOLOGY

The process of planning for the audit of inequalities began before the formal request was received by the ECNI. The purpose of the audit was to identify key areas of potential inequality.

At the outset all health and social care organisations participated in 3 planning workshops. The first workshop held in June, was facilitated by John Kremer (QUB), who along with members of the ECNI s75 Advisory Group, have made a major contribution to the new Section 75 Guidance. Representatives from the ECNI Statutory Duty Unit were also in attendance and provided a valuable contribution to the discussions.

The second and third workshops were used to bring together the 'Emerging Themes' document and to identify other areas for potential collaboration. This collaborative approach has been maintained through regular meetings.

At a regional level all health and social care organisations have worked collaboratively to gather emerging themes in relation to key inequalities experienced by the nine equality categories – as detailed in Table 1 below. Equality leads from each of the organisations detailed below, analysed collated data (qualitative and quantitative). This data was disaggregated by the Section 75 categories to develop indicators of levels of inequalities. Appendix 1 of this report details the outcome of this piece of work entitled 'Emerging Themes'. It became evident in the course of conducting the inequalities audit that there were a number of recurrent cross cutting themes such as measures to improve access to services, communication and information; service monitoring; measures to promote, participation and inclusion as well as service specific, procurement and employment related issues which in turn has influenced the format and content of the Trusts' action-based plans. It is important to note that the emerging themes section of this document (appendix 1) will be continually updated. Equality leads in each of the health and social care organisations will regularly review the relevant literature and update the working document which will be made available on all the organisations' websites. The document can then be used as evidence for future screening and equality impact assessments and will be a useful resource for both health and social care staff and representative organisations.

TABLE 1

Equality Group	Lead HSC organisation for collecting data
Religious belief	South Eastern HSC Trust and Southern HSC Trust
Political opinion	South Eastern HSC Trust and Southern HSC Trust
Racial group	SE HSC Trust and Southern Trust
Age	Northern Ireland Ambulance Service and NI Fire and Rescue Service
Marital status	Belfast HSC Trust

Sexual orientation	Business Services Organisation, Southern HSC Trust and Western HSC Trust.
Gender	Business Services Organisation, Southern HSC Trust and Western HSC Trust.
Disability	Northern HSC Trust and Business Services Organisation
Dependency	Business Services Organisation

Whilst a considerable amount of work has been taken forward in collaboration with all health and social care organisations, during the progress of this work it became clear that it would be appropriate for the Trusts to work together to develop and consult of their action-based plans. The Trusts have the same functions and were established over 3 years ago. The other regional organisations have only been established for over a year and whilst their functions relate to those of the Trusts, they decided it was more appropriate to develop separate plans and consult individually.

Within the Trusts the Senior/Executive Management Teams were informed of the specific requirements in the new guidance, the timeframes and provided with details of the proposed way forward.

The inward focus of the audit of inequalities involved dialogue and engagement with key directorates including Human Resources, Service Directorates and Health Improvement Teams. Given that the audit and associated action-based plan were to be relevant to the functions of the Trusts, the involvement of Trust staff was integral to relating the identified inequalities to the relevant functions of the Trusts. Staff within the directorates considered the emerging themes identified and drew up actions they felt would better promote equality of opportunity in relation to their functions and also paying consideration to the emerging themes already identified.

As the health and social care Trusts have the same functions, the Trusts worked collaboratively to identify key actions that can be taken forward regionally – in order to provide consistency of approach and avoid duplication of work. Each of the Trusts however has also identified local actions that relate directly to the inequalities identified in their Trust area.

EVIDENCE USED TO IDENTIFY KEY INEQUALITIES AND DEVELOP ACTION-BASED PLANS

The Trusts have gathered and utilised a breadth of knowledge to develop their action-based plans.

Health and social care organisations worked collaboratively to develop the ‘Emerging Themes’ document in Appendix 1. This document details the key inequalities identified from the research and literature available on the Section 75 categories. The research examined is not intended to be an exhaustive list

of all related literature but is instead an attempt to gather the main themes that have emerged in recent years. It is important to acknowledge at the outset that this 'Emerging Themes' document is not intended to be an academic literature review. The document aims to provide summary of the key issues rather an exhaustive list of relevant equality issues.

By the time this report is made available on our websites new information will be emerging and will continue to do so. With this in mind, health and social care organisations who contributed to the 'Emerging Themes' document are committed to regularly reviewing relevant literature and updating the working document which will be made available on all the organisations websites. As previously stated the document can thereafter be utilised to inform future screening and equality impact assessments and will be a useful resource for both health and social care staff and representative organisations.

Health and social care organisations have been engaging with individuals and representative groups over the lifetime of their equality schemes. This ongoing engagement has lead to increasing knowledge of the barriers face by the Section 75 categories and has provided a framework for the draft action-based plans.

One example of the ongoing engagement has been the work undertaken to develop the Trust's Disability Action Plans (DAPs). The Plans were developed in partnership with key disability organisations and the regional workstreams that have emerged from this work continue to meet regularly to take forward the actions. The knowledge the Trusts have gleaned from this ongoing engagement can not be underestimated and it has produced many of the disability related issues in the action-based plans. Another example is the pre-consultation process in relation to the race related actions detailed in the action-based plans. A number of organisations were pre-consulted on the key issues identified through the inequality audit and their views have contributed to shaping a number of key actions detailed in the Trusts draft action-based plans.

For example, with regards race equality pre-consultation took place with a range of voluntary and community organisations with the aim of firstly, gauging consultees' views on the emergent themes from the inequalities audit and secondly, to gain a sense of key priorities. Organisations included NICEM, Wah Hep Chinese Community Association, Craigavon Intercultural (Migrant Workers) Programme, Travellers Safe and Well Project SHSCT, Craigavon Muslim Women's Association, Newry and Mourne Ethnic Support Centre and Challenge for Change Southern Cluster. Other organisations that were pre-consulted with included South Eastern Rural Network, Committee on the Administration of Justice (CAJ), Disability Sector Organisations affiliated to the work of the Trusts Disability Action Plans, Trade Unions etc.

In considering the Older People element of the Age category NIAS has recently engaged with the Older People's Advocate and Age NI. Given the demanding timescales associated with the consultation on Schemes, the

outcomes of this engagement will be incorporated into the results of the Trusts' formal consultation process to inform final schemes and action plans, prior to submission to the Equality Commission.

In 2001, the Department of Health Social Services and Public Safety (DHSSPS) commissioned a literature review which was to assist with the setting of priorities for the Department's five year Equality Impact Assessment Programme. The remit of the review was to identify, from a range of academic and other publications, significant equality of opportunity issues relating to service delivery, policy development, and implementation of, health and social services for each of the nine Section 75 categories. The key function of the review was to summarise the information sources and findings emerging from the literature. The outcome of the project was the publication *'Literature Review:" Equality of Opportunity" in Relation to the DHSSPS Draft Equality Scheme'2*, carried out by Bunting (2001), and published by the DHSSPS in March 2001. This report provided a wealth of information in regards to each of the equality categories and further identified a wide range of recommendations aimed at facilitating greater equity in access to health and social services in Northern Ireland. The recommendations from this report have made an invaluable contribution to both the 'Emerging Themes' document and the subsequent draft plans.

In 2004, The Northern Ireland Statistics and Research Agency (NISRA) produced a report which provided for the first time an overview of a wide range of available data relating to differences between groups of the population that are pertinent to health and social care. The report drew together wide ranging information to document inequalities in health and social care in Northern Ireland that were relevant to the Section 75 equality categories. NISRA has also developed a website to collate and disseminate statistics and research relevant to equality of opportunity and its promotion within the Northern Ireland public sector. The information provided is from across government and provides detailed datasets specific to Section 75 categories and policy areas, together with related publications and a comprehensive series of relevant links. Both the report and website have provided a framework for much of our work and have been useful resources when developing the action-based plans.

Throughout the lifetime of the Trust's equality schemes a number of Section 75 screening templates and equality impact assessment have been completed. This has resulted in a wealth of knowledge both in considering the impact internally and in the extensive feedback received from consultees. This information has informed the 'Emerging Themes' document and action-based plans.

Analysis of the complaints received by health and social care organisations is always an effective measure of the barriers faced by service users when accessing services. Whilst the complaints are not categorised by Section 75 categories the analysis did identify that the main issues raised were staff attitudes, access to services, communication/information barriers and equality

in treatment and care. This analysis has informed the format and content of the action-based plans.

The Information & Analysis Directorate of DHSSPS has been working on updating the available administrative datasets to ensure more comprehensive data is available across the nine equality categories. The intention is to develop a set of analyses that can be revisited at regular intervals, thereby allowing an ongoing picture of the issues emerging. This includes completing an updated and more comprehensive review of mortality associated with various equality groups to develop the analysis included in "Differences in mortality rates in Northern Ireland 2002 - 2005: A Section 75 and social disadvantage perspective" (McClelland, 2008).

The Northern Ireland Mortality Study (NIMS) links deaths which have occurred to those counted in the 2001 census and can be used in analysis of the first seven of these - though it is noted that ethnicity may be of limited use because of small numbers recorded at the 2001 Census. The NIMS study allows us to look at individuals and their Section 75 characteristics as at the 2001 census and produce a more accurate analysis of the mortality data, rather than using area as a proxy. In addition a S75 analysis of birth rates to teenage mothers using fertility information from the Northern Ireland Longitudinal study (NILS) will examine differences by religious belief and other equality groups such as ethnicity, dependants, disability and marital status providing numbers are sufficiently large. NILS is a large scale, representative, data linkage study of approximately 500,000 of the Northern Ireland population.

DEVELOPMENT OF ACTION-BASED PLANS

The Trusts have developed their action-based plans to promote equality of opportunity and good relations which are based on the context of their functions. Action measures will be implemented through the framework of the Trusts' Equality Schemes. The Trusts have linked the development of action-based plans to their corporate planning cycles so that equality of opportunity and good relations are incorporated and mainstreamed at a strategic level into Trust business.

In developing the action-based plans, the Trusts have considered what inequalities can be addressed through the exercise of their specific functions and/or what opportunities exist to promote equality of opportunity and good relations for the nine equality categories. The action-based plans outline the desired outcomes the Trusts aim to achieve with related performance indicators and timescales.

It is important to note that action plans are flexible, adaptable and responsive to changing circumstance and needs.

The Trusts' action-based plans are included as an appendix to the Trusts' equality schemes and are available on Trust websites as follows:

http://belfasttrust.hscni.net

http://www.northerntrust.hscni.net

http://www.setrust.hscni.net

http://www.southerntrust.hscni.net

http://www.westerntrust.hscni.net

http://www.niamb.co.uk

Alternatively you can request a copy of the action based plans from the relevant equality leads. Contact details are provided below.

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TIMELINE FOR THE DEVELOPMENT OF 2ND GENERATION EQUALITY SCHEMES AND ACTION-BASED PLANS

Pre-November	Preparation of Draft Equality Scheme
1st November	Official call up letter from Equality Commission to Chief Executives
2nd November	Meeting with Equality Leads
Mid-November	Consult with Equality Commission on first draft of the Equality Scheme
End-November	Formalise arrangements for public consultation (e.g. targeted consultation, mailshot, advert etc.)
Early December	Consult with Equality Commission on proposed consultation arrangements
Mid December	Obtain Approval of SMT/Trust Board
January to March 2011	Formal Consultation
April 2011	Review Responses Received and obtain Trust Board approval
1 May 2011	Submit Equality Scheme and Action Based Plan to the Equality Commission
Every 3 years thereafter	Monitor and Review of the Scheme and Plan

Appendix 1 –Emerging Themes

HSC Audit of inequalities: Emerging Themes: Gender

A. Emerging Themes for both Men and Women			
What are the Equality/ Inequality Issues?	**Potential solutions where these are offered in the literature Policy/Practice Issues?**	**Source of Evidence**	**Date**
1. Address Gender Blindness: Most health and social care strategies and policies are written in gender neutral language with general targets set for the whole population.	Need to recognise that men and women differ in their health and social care needs throughout their lifetime. Recognise groups that are particularly vulnerable e.g. older women, ethnic minority women, women living in rural areas, men who have experienced sexual abuse, and men who have experienced domestic violence, men in their role as fathers. Should be recognised in all Equality Impact Assessments of decisions and policies	Key Inequalities in NI. ECNI Men's Action Network, Derry	2007 2010

B. Emerging Themes specific to women			
What are the Equality/ Inequality Issues?	**Potential solutions where these are offered in the literature Policy/Practice Issues?**	**Source of Evidence**	**Date**
1. Structural inequalities: e.g. low pay, lack of childcare, lack of involvement in internal decision making etc.	HSC organisations already play a key role in this area. How can we build on this good practice? Recognise that this is a huge area. What additional actions can HSC organisations take to tackle the structural inequality between women and	Women's Health in Ireland Other Borders Women in Disadvantaged Communities	2006 2005 2009

	men?		
2. Lack of involvement in planning and decision making: of health care services particularly by more marginalised women e.g. lesbian women, women with disabilities, older women, women from black and minority ethnic groups including traveller women, women from disadvantaged communities etc.	Improved participatory approaches to planning and delivery of HSC services. Monitor who we are talking to. Work in partnership with community groups to provide capacity building for women from the most marginalised groups.	Women's Health in Ireland Other Borders Women in Disadvantaged Communities	2006 2005 2009
3. Mental Health Issues: High rates of mental ill health, in particular for travelling women, women with disabilities, lesbian women etc. - has huge consequences for women accessing training, employment, education or participating in public life.	Crucial that mental health services planning takes into account the needs of the most marginalised women. (See Item 2).	Women's Health in Ireland Other Borders Women in Disadvantaged Communities	2006 2005 2009
4. Maternity Services: Particular issues for women with disabilities, travelling women and BME women, younger women etc.	Crucial that maternity health services planning takes into account the needs of the most marginalised women. (See item 2).	DHSSPS Literature Review Ethnic and Social Inequalities in Women's Experience of Maternity Services, Care Quality Commission	2006 2007
5. Domestic and Sexual Violence and Abuse: GP's, A and E and maternity staff are important points of contact. Their response is critical and can make an immense difference to the future choices of the woman.	Ongoing training for GPs, A and E and maternity staff. Evaluate and update training. Need to develop and regularly review DV policies and protocols for referral and asking the routine questions re DV.	NI Women's Aid Federation DV and Health Professionals DHSSPS Literature Review. Western Interagency Partnership on Domestic Violence	2003 2006 2010
6. HSC Staff Domestic Violence Policies	Ensure all Trusts have in place a staff Domestic Violence Policy. All staff trained in regard to its implications.	Unison and WIADV Partnership	2010
7. Domestic Violence and particular issues for marginalised women: Women with disabilities or from ethnic communities or women, who are lesbian,	Targeted programmes for the most marginalised women. Need to review how current services are or are not meeting their needs	NI Women's Aid Federation DV and Health Professionals DHSSPS Literature Review Western Interagency partnership	2003 2006 2010

have additional barriers to accessing support for Domestic Violence.		on DV	
8. Attitudes of staff: Many women, particularly those who are most marginalised frequently experience staff attitudes as unsupportive/judgemental.	Ongoing staff training in equality, diversity etc. Prioritise attendance by senior managers/team leaders.	DHSSPS Literature Review Ethnic and Social Inequalities in Women's Experience of Maternity Services, Care Quality Commission	2006 2007

C. Emerging Themes specific to men			
What are the Equality/ Inequality Issues?	**Potential solutions where these are offered in the literature Policy/Practice Issues?**	**Source of Evidence**	**Date**
1. Lack of research: Ignorance and lack of understanding of men's needs in this area.	More research: Key areas: Men as victims of domestic abuse, male health needs, role of fathers, homophobia and homophobic attacks, men as perpetrators and victims of violence, needs of rural men.	DHSSPS Literature Review Priority issues which need to be addressed in the Men's Action Plans (Men's Action Network; Work with Young Men Unit; The Men's Project)	2006 2009
2. Tackling health inequalities in relation to men ***:** For example, men tend to die younger and are more likely to commit suicide etc.	Developing a Men's Health Strategy similar to the policy developed in the Republic of Ireland (2008). Health services need to see the benefit of making health services more accessible to men. A great deal is about prevention.	McEvoy and Richards: cited in DHSSPS Literature Review Priority issues which need to be addressed in the Men's Action Plans Men's Action Network	2006 2009 2010
3. Addressing risk taking behaviours by men.	Increased advice and health information in places accessible to men e.g. workplaces sporting venues, pubs, social clubs etc.	McEvoy and Richards: cited in DHSSPS Literature Review Priority issues which need to be addressed in the Men's Action Plans	2006 2009
4. Social attitudes re: men's health: Cultural norms, false perceptions, ignorance and lack of confidence.	Provide staff training to challenge stereotypes.	Priority issues which need to be addressed in the Men's Action Plans	2009
5. Men as fathers: Men often feel	Improved awareness of midwives to	Fathers Direct: cited in DHSSPS	2006

excluded from decisions re: child birth and care of their child.	encourage new and prospective fathers to be actively involved in decision regarding their baby.	Literature Review Priority issues which need to be addressed in the Men's Action Plans	2009
6. Decision making: While many key decision makers are male very few are working class men or young men.	Improved participatory approaches to planning and delivery of services. Monitor who we are talking to. Work with community groups to build capacity of the most marginalised people.	Priority issues which need to be addressed in the Men's Action Plans.	2009
7. Men and domestic violence: HSC staff reluctant to acknowledge male victims.	Raise staff awareness of the issue. Develop appropriate support services for men.	Priority issues which need to be addressed in the Men's Action Plans	2009
8. Men and mental health: Lack of support structures – particularly men in rural areas, plus reluctance to discuss issue with GPs.	Need more awareness of men's issues when developing mental health services.	Health Inequalities CAWT Report	2005

D. Emerging Themes specific to transgender people

What are the Equality/ Inequality Issues?	Potential solutions where these are offered in the literature Policy/ Practice Issues?	Source of Evidence	Date
1. Lack of awareness and understanding resulting in behaviour by health staff that can be profoundly humiliating: Most people do not knowingly interact with transgender people and subsequently do not have any life experience to help inform their interactions in the workplace.	**Equality and diversity training for staff:** should include awareness of transgender issues and should challenge attitudes that undermine people's gender identify. Increase staff capacity to interrupt prejudicial behaviour and attitudes.	Fair for All: NHS Scotland. The Luck of the Draw - a report on the experiences of trans individuals reporting Hate Incidents in NI, Institute for Conflict Research	2008 2010

Some health staff refuse to use the appropriate gender pronoun. Many make inappropriate assumptions about the person's sexual orientation.			
2. Choosing appropriate health services/ward: Many services are set up specifically for men or women e.g. sexual health services. These may exclude transgender people as they may need to access clinical services due to their birth gender not their true gender.	It is important to consider the options with the person and to recognise the person's wishes and true gender and not to send them to a service or place them on a ward determined by the proposed clinical treatment.	Fair for All: NHS Scotland	2008

HSC Audit of inequalitites: Emerging Themes: Age: Young Persons

What are the Equality/ Inequality Issues?	Potential solutions where these are offered in the literature Policy/Practice Issues?	Source of Evidence	Date
Educational/Behavioural Outcomes and Health: Girls are advantaged in cognitive, educational, behavioural outcomes and in general health, but are more likely to be overweight at age 5. Parents longstanding illness and mental distress linked to poorer cognitive, educational and behavioural assessments and general health in children.		OFMDFM - Consequences of childhood disadvantage in Northern Ireland at age 5 http://www.ofmdfmni.gov.uk/the_consequences_of_childhood_disadvantage_in_northern_ireland.pdf	June 2010
Negative impact of poverty for children from ethnic minorities, with disabilities and LGBT young people: Negative impact of poverty on young peoples' health and wellbeing including higher prevalence of mental health, rates of suicide, self harm and teenage pregnancy.	Statutory agencies must be encouraged to respond to the evidence based link between poverty and poor health in children and young people. Multi-agency approaches must be developed and urgent provision made of fully resourced mental health and regional based sexual health services put in place to guarantee the physical and mental health needs of children and young people are met. Inqualities and discrimination in health care policies and practices for children in minority groups should be challenged.	NICCY's 2008 Review of Children's Rights in Northern Ireland Children in Poverty - Anti-Poverty Network http://www.niccy.org/uploaded_docs/CRR/71784_NIC71784%20Childrens%20Rights%20Text%20intro.pdf Children's Rights in NI – NICCY in association with Queens University Belfast http://www.niccy.org/article.aspx	2008 2004

		?menuid=381	
NI has youngest population in UK, 25% are aged under 18, more than one third of children in NI live in poverty (c.122,000), of these 44,000 experience severe poverty. People living in the most deprived electoral wards have poorer life expectancy, higher death rates, higher rates of hospital admission, more infant deaths and more suicides than in the NI population as a whole. Also, high rates of suicide amongst young people in NI - suicide rate for young males living in deprived areas nearly twice that for those living in wealthier communities. Of the 2,500 Travellers in NI, about half are aged under 16. Many Traveller families experience poor sanitation and access to electricity and water, have poor access to healthcare and education. Increased risk of early childhood mortality than in settled children due to the increased likelihood of accidents and preventable diseases. 12 yr old children have almost 3 times level of tooth decay for age group (against UK average). Children living in the 20% most deprived wards are almost twice as likely to have experienced dental decay as children from the 20% most affluent wards.		Save the Children – What we do in Northern Ireland http://www.savethechildren.org.uk/en/docs/Northern_Ireland_CB_07.pdf Northern Ireland NGO Alternative Report Submission to the United Nations Committee on the rights of the child for consideration during the committee's scrutiny of the UK Government report (July 2007) http://www.savethechildren.org.uk/en/docs/NI_NGO_ALTERNATIVE_REPORT.pdf	2007/ 2008 March 2008

Between March 2005 and March 2007, the number of under-18s in treatment for drug and/or alcohol abuse more than trebled from 271 to 847, representing 15% of the total number of 5,583 individuals in treatment. Young people from poorer families are more likely to engage in smoking, drinking alcohol, solvent and drug abuse than young children from wealthier backgrounds.			
Medical and social work professional awareness of cultural issues and complex child protection cases. Issues for nurses training re obtaining consent of children re (minor) medical procedures and in communicating effectively with children re surgical procedures.	Training needed - medical professions need specialised training on particular cultural issues that arise for ethnic minorities and training required on consent issues.	Children's Rights in NI – NICCY in association with Queens University Belfast http://www.niccy.org/article.aspx?menuid=381 Northern Ireland NGO Alternative Report	2004
Newly qualified social workers dealing with complex child protection cases without the necessary training, raises serious issue of child protection and protection of the rights of vulnerable children in custody and secure care. Example given of untrained staff dealing with mental health issues responding inappropriately to young person following a self-harm incident Difficulties for minority ethnic groups in registering with GPs & dentists, leading to additional pressures on emergency clinics. Responses of health		Submission to the United Nations Committee on the rights of the child for consideration during the committee's scrutiny of the UK Government report (July 2007)	March 2008

professionals influenced by stereotyping.			
DHSSPS dual set of complaints systems potentially confusing: The Children Order procedure for complaints re childrens' services and the Wilson Procedures, applicable to services provided by health and social care services potentially confusing for children and young people attempting to make complaints on own behalf.	The Trusts should engage in proactive complaints publicity and awareness raising among vulnerable groups of children and young people about the Rights and complaints procedures.	Cousins et al, 2003 Children's Rights in NI – NICCY in association with Queens University Belfast http://www.niccy.org/article.aspx?menuid=381	2004
Children in care: Expressed frustration at not being involved in decisions made regarding their care plans and the lack of information or feeling of genuine involvement in reviews. Evidence of experience of disadvantage due to lack of placement stability, special educational needs, higher rates of teenage pregnancy than peers, mental health and well-being affected by instability, lack of contact with their birth family; placement moves; change of schools and friendship networks	Information should be discussed in a way that they can understand and, whenever the young person is talking, the foster carer should be out of the room to facilitate them speaking freely.	Children's Rights in NI – NICCY in association with Queens University Belfast http://www.niccy.org/article.aspx?menuid=381 Save the Children and the Children's Law Centre http://www.savethechildren.org.uk/en/docs/NI_NGO_ALTERNATIVE_REPORT.pdf	2004 2007/2008
Disabled children and their families frequently raise issues about poor, or late, assessment of needs. Services required to meet these needs are not always locally available.	Full implementation of the rights of children with disabilities requires effective assessment of their needs and adequate resourcing of appropriate services.	Save the Children and the Children's Law Centre http://www.savethechildren.org.uk/en/docs/NI_NGO_ALTERNATIVE_REPORT.pdf	2007/2008
Mental Health issues. Over 20% of children under 18 suffer significant mental health problems. Mental Health (NI) Order 1986 fails to		Northern Ireland NGO Alternative Report Submission to the United Nations Committee on the rights	March 2008

require age-appropriate in-patient facilities for children, consequently often placed in adult facilities. Some young people sent to England for treatment (e.g. those with complex mental health problems or eating disorders). Disruption to family life, education and work opportunities, social and leisure activities with friends. Incidence of mental health problems is disproportionately high among children and young people with disabilities, living in poverty, in conflict with the law, in or leaving care, who identify as LGBT. Less than 5% of the mental health budget is spent on child and adolescent mental health services, despite under-18s representing approximately 25% of NI population.		of the child for consideration during the committee's scrutiny of the UK Government report (July 2007)	

HSC Audit of inequalities: Emerging Themes: Age: Older People

What are the Equality/ Inequality Issues?	Potential solutions where these are offered in the literature Policy/Practice Issues?	Source of Evidence	Date
For Service Users			
Older people are more likely to be discriminated against in relation to healthcare.	None offered.	ARK NI Research Update Number 61 – Attitudes to Age and Aging in Northern Ireland	June 2009
Older people are more likely to have a sedentary lifestyle than younger people: Of those aged 75 and over, 63% were sedentary.	None – statistical report only.	Equalities and Inequalities in Health and Social Care in Northern Ireland – A Statistical Overview, DHSSPS	2004
The vast majority of delayed discharges were among older people.	None – statistical report only.	Equalities and Inequalities in Health and Social Care in Northern Ireland – A Statistical Overview, DHSSPS	2004
Social isolation is caused by a number of factors: Including differential access to and availability of health and social care services.	None – statistical report only.	ECNI – Statement on Key Inequalities in Northern Ireland	October 2007
Research highlighted the failure of the NHS in addressing the mental health needs of older people.	None.	ECNI – Statement on Key Inequalities in Northern Ireland	October 2007
Differential access to transport may be producing a profound effect in access to healthcare for older people, particularly those with a disability and/or in rural areas.	None.	ECNI – Statement on Key Inequalities in Northern Ireland	October 2007
Social exclusion and pensioner poverty are a particular issue for older women.	None.	ECNI – Statement on Key Inequalities in Northern Ireland	October 2007

There is no legal basis in Northern Ireland on which to challenge age discrimination in the provision of goods and services, including health and social care services.	Recommends that the law in Northern Ireland be amended to outlaw discrimination on age grounds when people are accessing goods, facilities or services.	Making Older People Equal: Reforming The Law On Access To Services In Northern Ireland - Report for the Changing Ageing Partnership (CAP) by the Institute of Governance, School of Law, Queen's University Belfast	February 2009
Older women are the majority in Northern Ireland: Health and social care organisations must take account of their needs.	Tackle inequalities in coronary heart disease. Recognise increase in breast cancer. Redress the imbalance given to osteoporosis and arthritis, blindness and deafness for older women.	Northern Ireland Women's European Platform – 12 Critical Areas	
Older people have lower expectations of healthcare provision: Anecdotal information from health care providers suggests that professional pragmatism in the rationing of delivery of services impacts on the care delivered to older people.	Further research is required to establish the perceptions and socially held beliefs about how older people are valued and as a result, treated when health services are delivered to them. The way in which caseloads are prioritised particularly within acute or secondary care and specialisms of cardiology should be investigated.	Older People's Experience of Health Services in Northern Ireland – Help the Aged, OFMDFM and NIHRC	July 2004
Social exclusion exacerbated in later life: Women's income in retirement is on average only 57% that of men's. Ethnic minority pensioners are more likely to be in low income households than white pensioners. Ethnic minority groups are also more likely to experience multiple deprivation. There are two million people with sight problems, 90% of whom are over age 60.	Need a more responsive model for services for older people that addresses their needs. Encourage take up of benefits and entitlements. Review of pensions.	A Sure Start to Later Life - Ending Inequalities for Older People - Social Exclusion Unit Final Report	January 2006
Specific needs of older people from ethnic minority backgrounds.	The differences between and within ethnic minority groups in access services need to be taken into account by policy makers and	Social Inequalities in Later Life: the socio-economic position of older people from ethnic	Autumn 2000

	planners.	minority groups in Britain, Kings College London	
Pensioner poverty in Northern Ireland remains high: Older, single, female pensioners experience some of the highest levels of poverty.	Extend clause in Welfare Reform Act 2009 related to state pension credit schemes to Northern Ireland. An innovative approach to benefit uptake is needed.	Age NI Briefing Paper – Evidence to DSD Committee on the Welfare Reform Bill	May 2010
For HSC Staff			
Carers are more likely to be found among older workers: Peak age for caring is between 55-59 when one in four people is a carer. **Carers are more likely to give up work early in order to provide care:** Particularly for workers just before end of employment. **Carers find it more difficult to return to work after a period of caring.**	Screening and Equality Impact Assessments is key in assessing whether employment policies have an adverse impact on carers.	Source to be provided	
People aged 45-54 had the highest risk of suffering from a psychological disorder, while those aged 65 and above were the least at risk.	None – statistical report only.	Equalities and Inequalities in Health and Social Care in Northern Ireland – A Statistical Overview, DHSSPS	2004
The incidence of cancer, diabetes, heart attack and stroke increases with age.	None – statistical report only.	Equalities and Inequalities in Health and Social Care in Northern Ireland – A Statistical Overview, DHSSPS	2004
The incidence of informal care was highest among those aged 45 to 64, with approximately a fifth of respondents acting as carers. Women aged between 45 and 64 were particularly likely to be carers.	None – statistical report only.	Equalities and Inequalities in Health and Social Care in Northern Ireland – A Statistical Overview, DHSSPS	2004

Negative assumptions about capacity which lead to discrimination are considered to be barriers for older workers.	Employment Equality (Age) Regulations (NI) 2006 only partly address the issues of age discrimination in employment.	ECNI - Awareness of Age Regulations 2006 and Attitudes of the General Public in Northern Ireland towards Age Related Issues	June 2008

HSC Audit of inequalities: Emerging Themes: Religion

What are the Equality/ Inequality Issues?	Potential solutions where these are offered in the literature Policy/Practice Issues?	Source of Evidence	Date
A. For Service Users			
Blood Transfusion: Many Jehovah's Witnesses reported experiencing stigmatisation for their refusal, on religious grounds, to accept blood-based treatments.		Narrowing the Gaps Equality and Diversity, NHS	2008-2013
Contraception.	Encourage open consultation between staff and patients to identify and address the needs of different religious groups.		
Dietary and clothing needs: Lack of appropriate meals in hospital settings (e.g. Halal or Kosher foods). Issues relating to modesty and the wearing of standard hospital garments.	Female staff as required. Many hospitals have been cited as now providing halal meat		
Lack of specific care places for older people from minority religious groups.			
Medications.			
Mental Health Issues.			
Chaplaincy and facilities for worship: Access to spiritual and religious care in hospitals, particularly for those of non-Christian faiths, is somewhat limited.	Conduct an audit of places of worship in hospitals and other health care settings. More multi-faith prayer rooms in health and social care settings. Develop guidelines such as those produced by the Scottish Executive.	Weller et al, Religious and Spiritual Care in a H&SC Context Sheikh, A hospital chaplaincy units show bias towards Christianity	2001 2004
Circumcision: Particular concern for Jews and Muslims. The availability of the			

operation on the NHS tended to vary according to geographic location. Concerns over unlicensed GP's without proper insurance or authority.			
Burials and Cremation: e.g. Muslims reported being refused access to prepare the body of the deceased.	Co-ordinator in hospitals whose role would be to contact community members to administer the appropriate rites.		
Attitudes and behaviour of staff.	Staff training in religious equality. Continued emphasis on staff education and awareness programmes on the requirements of different faith groups delivered across H&SC including primary, secondary and community.	Weller et al (2001:71) Religious Discrimination in England and Wales, Home Office Research Study	2001
B. For HSC Staff			
To adopt a zero tolerance approach: To all incidences of, and reasons for, attacks motivated by sectarian, religious, racist, or hate prejudice, including those on symbolic premises, cultural premises and monuments. In light of the economic challenges that we all face, we must address the issue of duplication in the provision of health and leisure services. (14 of the 15 most deprived areas in Belfast are highly segregated). **Update the flags protocol:** Which was established in April 2005 by OFMDFM.		Programme for Cohesion, Sharing and Integration (CSI) Faith and Human Rights	Sept 2010 NIHRC 2010

HSC Audit of inequalities: Emerging Themes: Political Opinion

What are the Equality/ Inequality Issues?	Potential solutions where these are offered in the literature Policy/Practice Issues?	Source of Evidence	Date
A. For Service Users			
Research: More research is needed on the impact of political opinion on access and usage of health and social services.	**Research:** Dedicated research should be commissioned which can more definitively test the impact of the Troubles on levels of need. In-depth investigations should be conducted on the impact of segregation, paramilitary feuds, and population intimidation.		
Violent Interface areas: Reluctant or unable to use health and social services in the "other" community area e.g. North Belfast residents continue to have restricted access to facilities and services which are perceived to be situated in the "other" community. The ministerial Panel will: urgently address the physical and community division created by interfaces with the support of communities.	Develop and build on links with voluntary and community groups operating in this area e.g. victims groups, community groups in interface areas. Location of future facilities – careful consideration should be given to the location of future regional facilities within the Board area. Location within North and West Belfast should be considered a priority. New facilities should be located on peace-lines and should be fully accessible to both communities. Reduce and eventually eliminate segregated services.	Jarman Smyth et al, Caring Through the Troubles Programme for Cohesion, Sharing and Integration (CSI)	2002 2001 Sept 2010
Service Inaccessibility: The impact of the Troubles and interface violence has a particularly profound impact upon North and West Belfast with high levels of need and yet regional services tend to be	Data Collection – it is recommended that the existing collection of data within Trusts is reviewed to ensure that data is collected which facilitates the monitoring and analysis of the impact of the Troubles.	Smyth et al, 2001 "Caring Through the Troubles"	2001

located in other areas such as South Belfast. These services are often perceived to be inaccessible for those living in North and West Belfast. It was further suggested that there was a higher than average need for adolescent mental health services in North and West Belfast but that very little in terms of service provision exists in the area.	Social and psychological reconstruction – consideration should be given to establishing a dedicated facility or multi-disciplinary initiative for the reconstruction of communities affected by the Troubles in Northern and West Belfast. This should involve health, social services and community development and should offer advice, research, and training on a Northern Ireland wide basis.		
Children and Young People: The troubles and interface violence have a profound impact upon children and young people i.e. as victims and witnesses of violence and as children of ex-prisoners or members of the security forces. There is evidence to suggest they tend to be reluctant users of statutory services due to issues of trust and confidentiality. The ad hoc nature and under-funding of child and adolescent psychiatry services in Northern Ireland greatly impacts upon the provision of services to children and young people affected by the troubles. It was further suggested that there was a higher than average need for adolescent mental health services in North and West Belfast but that very little in terms of service provision exists in the area.	It is clear that there is a need for further research; policy and service development to meet the needs of this group.	Smyth et al	2004
Another important area of concern is the impact of imprisonment on the children of politically motivated prisoners/ex-	Shirlow (2001) maintains that it is obvious that the psychological and other difficulties experienced by ex-prisoners and their	Shirlow, 2001	2001

prisoners. Evidence suggests that many of these children experience bullying, deprivation, a breakdown in family relationships and loss of opportunity as a result of the imprisonment. These factors coupled with discrimination, stigma and overt hostility can often have a traumatic impact.	families cannot be addressed by conventional support structures. This is because many ex-prisoners and their family are suspicious of institutions which are supported or influenced by state agencies. It is therefore imperative that health and social care providers begin to build a relationship of trust and reciprocity with ex-prisoner based organisations in order to meet the needs of ex-prisoners and their families.		
Politically motivated ex-prisoners and their families. **Political ideology can often act as a barrier in access and uptake of services provided by statutory/voluntary agencies**. The authors suggest that the politically motivated ex-prisoners and their families have a **tendency not to use professional and voluntary organisations which do not take into account their status and political ideology**.	Mental and emotional health appears to be an important issue for ex-prisoners and their families. **Access to confidential services which provide emotional support** is a key concern for many ex-prisoners. Evidence continues to suggest that many ex-prisoners and their families are **suspicious of institutions which are supported or influenced by Government agencies**	McEvoy et al 1999	1999
Victims and Survivors of the conflict: The DHSSPS evaluation revealed: There are only a relatively small number of dedicated services for victims across the general HSS. There was a need to increase awareness across the mainstream sector in respect of	One of the values underpinning the Northern Ireland Victims Strategy is that all victims (and their close relatives, partners and carers) should have equality of opportunity in regards to access to, and participation in, and benefits of services (see OFMDFM Victim's Strategy, p.2). The present location of the Family Trauma	DHSSPS NI Victims Strategy	2003

victim's issues, needs and services. That there were particular specialities in which victims accessed services most frequently including pain management, physiotherapy, mental health etc but that these services had long waiting lists. That services for victims often were developed as a response to tragedies with service developments taking place on an ad hoc basis.	Centre and its accessibility to the whole population of Northern Ireland remains an issue of concern in that it was not readily accessible to a large number of the population. Some of the dedicated services for victims lacked recurrent funding. That greater coordination and transparency in service coordination and planning was required.		
Location of some services: Both statutory and voluntary, are not considered very accessible. **Fears about confidentiality.** **Lack of information and awareness about available and existing services.** **Lack of trust in social services.**	Some individuals who rely on public transport feel uncomfortable travelling to services located in areas not regarded as 'neutral' in sectarian terms.	Living with the Trauma of the Troubles, Social Services Inspectorate	1998
The author states that punishment beatings and shootings are often seen to be part of an 'acceptable level of violence' and that victims receive little sympathy. A deep suspicion and mistrust of the statutory authorities and the 'undeserving' character of victims currently militate against a 'joined-up' approach.	Statutory bodies either minimise the problem of community violence or remain indifferent to it. The net result is a disjoined response at both inter-sectoral and inter-agency levels.	Joined-Up Government: A multi-agency response to violence in NI, Know	2000
Participation and accessibility of services. Those bereaved and injured by security forces may be mistrustful of state provision.	**Training, organisational development and specific organisational policies are required**	The Cost of the Troubles Study, Incore	1999

B. For HSC Staff			
Violent Interface areas: Health and social care staff in North and West Belfast often work in volatile and stressful situations. **Restrictions on staff**: During the "marching season" and other disputes e.g. Drumcree often impede the normal and smooth delivery of services e.g. domiciliary services.	**Mainstreaming the Troubles for health and social care providers –** it is important that the challenges involved in delivering health and social services in communities affected by the Troubles become a mainstream concern. Staff operation under such circumstances should no longer be left to "get on with it".	Caring Through the Troubles, Smyth et al	2001
Duplication of services.			

HSC Audit of inequalitites: Emerging Themes: Marital Status

A person's `marital status` describes their relationship with a significant other. Some common statuses are: married, single, separated, divorced, widowed, engaged, annulled, cohabitating, deceased or civil partnership. As with most of the Section 75 groups, there is much overlap with other categories and those most synonymous with marital status would be gender and those with and without dependants. It would perhaps be most effective and meaningful to group these categories together since the issue of multiple identity can often exacerbate the inequalities experienced. Very often in cases taken to court, marital status and gender are used in conjunction as the proscribed grounds. The Sex Discrimination Order has made it illegal to discriminate against people in employment or service provision because of their marital status – it is only 30 years ago that a women could not enter into a hire purchase agreement without her husband's consent – if she was unmarried, she could not access contraception and she was obliged to give up work once she got married. Equal Pay legislation made it unlawful for someone to be paid less because of their gender or marital status. Since the 1970's the number of women in employment has increased by as much as a fifth. Working parents are now entitled to maternity and paternity pay and to request flexible working.

Much of the research for this audit has been done over the internet regarding marital status. Some of it applies to Northern Ireland and some of it nationally in the UK. The emerging themes are not just pertinent to marital status but predominantly exist as a result of multiple identity – i.e. with gender, dependants and/or ethnic minority and disability. Perhaps some of the most pronounced to suffer inequalities within the marital status category would be lone parents and this would be in terms of access to affordable childcare, younger lone parents may not have completed their education and thus their employment potential is affected. Mental health and domestic abuse are also emerging themes. Potential solutions to these inequalities would include more flexibility in terms of both service provision and employment, help with childcare, childcare facilities and general support mechanisms such as health improvement, sex education programmes and mental health awareness.

What are the Equality/ Inequality Issues?	Potential solutions where these are offered in the literature Policy/Practice Issues?	Source of Evidence	Date
General Issues			
Lone Parents: In Northern Ireland there are nearly 92,000 lone parents with 150,000 children, 25% of all families in Northern Ireland are one parent families, nearly half separated or divorced. In the UK 1 in 4 families is headed by a	Single people who are service users/staff. Single parents, staff or service users Potential staff.	Gingerbread N.I. Office for National Statistics (Social Trends Matthew Hughes) Family Resources Survey Census New TSN – the way forward	2010 2009 2004/05 2001

single parent who are bringing up 3 million children. Statistics show that a high percentage of lone parents are likely to be living on a low income in rented accommodation without savings and may be in debt. 90% of lone parents wish to work outside of the home at some stage.		Lone Parents Needs Assessment NHSSB, Gingerbread N.I., DHSSPS	1996
29% of children have no contact with their non-resident parent and for two thirds of children no contact has taken place since the separation of their parents.		"Families in Britain come in all shapes and sizes; we should acknowledge and value their diversity" source: Gingerbread	2009

Cross cutting issues with other Section 75 Categories			
Age			
Less than 3% of lone parents are teenagers. 80% of lone parents are aged 25-49 years. The majority of grooms were aged 40 and over with the average age of the husband age 33.4, (2009). Percentage of Brides aged under 25 in 2009 was 16.5%. Percentage of Brides aged 40 and over in 2009 was 11.8%. The average age of the Bride in 2009 was 31.1.		Gingerbread NI Census	1998 2001
For male civil partnerships the average age of partners was just over 39 (39.4 years), this compares to just under 36 (35.6 years for female civil partnerships).		NISRA	2009
Forced marriage frequently involves people under 18. Those with learning disabilities being forced in to marriage	Cultural: - Indian - Traveller	Ann Craft Trust (ACT) Forced marriage on people with learning disabilities.	-

showed at least 18% were still at school, 11% were under 17, 22% 18-21 and 23% 22-25 years old.	- Muslim - Asian		
Sexual Orientation			
Civil Partnerships: For 79 civil partnerships both partners were single, in the remaining 17 civil partnerships at least one partner had previously been married.			
The percentage of civil marriages in 2009 was 29. Within civil partnerships there were 46 male and 50 female partnership ceremonies carried out in 2009.		NISRA	2009
Religion, Faith, Belief			
2009 Marriages took place within these denominations: Civil: 2,330 (29.4%), Roman Catholic: 2,953 (37.2%) Presbyterian: 1,046 (13.2%), Church of Ireland: 805 (10.2%), Methodist: 202 (2.5%), Other denominations: 595 (7.5%) Mixed marriages and partnerships - 5% and 12% (Northern Ireland Life and Times survey (NILT), 2005). Each year around 10% of respondents to the NILT survey say their partner is a different religion to them.		NISRA Census NILT	2009 2001 2005
Gender			
Forced marriage on people with learning disabilities showed that 38% were male and 45% female. In the general population women are forced into marriage more frequently than	Male and female with learning disabilities - cultural.	Ann Craft Trust (ACT) Forced marriages on people with learning disabilities	-

men.			
Females comprised the majority of the population (51.3%) in Northern Ireland and the majority of lone parents (87%).	Women	Census 2001: Men and Women in Northern Ireland (2006). Equality Commission Report.	2001
59% of those on income support are women.	Women	DSD	2003
In the UK, due to caring for children, more women work flexitime than men and more men than women work fulltime		LFS	2002
In 2001-02 females accounted for 61% of undergraduate enrolments and 58% of postgraduate enrolments at N.I. Higher Education institutions.		DEL	2001-02
36% of men separated from their wives are more likely to have possible mental health problem, compared to 16% of married men.	Men	Gender matters - a consultation document (OFMDFM).	2005
40% of women who are divorced from their husbands are likely to show signs of a possible mental health problem. 22% of women who are either single or married show signs of a possible mental health problem	Women	N.I. Health and Social Wellbeing Survey. (Gender matters - a consultation document (OFMDFM)).	2001
Marital Status			
The number of marriages in Northern Ireland in 2009 was 7,931.	N/A	NISRA	2009
The following statistical data indicates the proportion of population (number of suicides) %. Married/cohabiting 58.8 (254) Single 30.2 (222) Separated/ divorced 6.9 (77) Widowed 4.1 (13)		British Journal of Psychiatry	2008
In Northern Ireland during 2009 there were	Men and women.	NISRA	2009

the following number of divorcees by area of residence: Male: 1,959; Female: 2.092.			
Suicide risks were lowest for women. Risks were also the lowest for people who were married or cohabiting with the excess risk associated with the single/never married and separated/divorced categories being maintained. Those living alone were associated with higher suicide risk.		British Journal of Psychiatry	2008
A 2006/7 survey indicated a higher proportion of single men smoked compared to married/cohabiting men.		Men in Northern Ireland: Report 3a - Olivia O'Riordan and Paula Devine.	December 2007
In terms of the marital status of lone parents, women (30.7%) were more likely than men (7.7%) to be single (never married). Men in this group, however, were more likely to be widowed than their female counterparts (44.8% vs. 24.8%).		Census 2001: Men and Women in Northern Ireland (2006). (Equality Commission Report)	2001
Nearly twice as many single men (4,621) than single women (2,456) are homeless (NIHE), 2001-02).		NIHE	2001-02
University of Ulster showed in previous monitoring data that the majority of new entrants were single 10% of full time students were married		University of Ulster	2002-2005
In terms of childcare facilities at the University of Ulster; the majority of students using the facilities are female with dependants, single, aged over 25 years and Catholic. The majority are white and two have a disability/long term health		University of Ulster - Review of Childcare Provision	2009

condition. The majority are full time students.			
People with learning disabilities can be forced into a marriage through: harassment; suggestion; coercion; kidnapping; blackmail; lack of capacity to consent (40%). In 67% of cases the mother and father were involved in the forced marriage.		Ann Craft Trust - ACT Forced Marriage of People with Learning Disabilities.	-
Lone parents with a disability or a child with a disability and a lack of family support are vulnerable to stress which means that for these parents, participation in the labour market is all the more difficult.		Women Living in Disadvantaged Communities: Barriers to Participation, Dr Helen McLaughlin on behalf of the Women's Centres Regional Partnership	-
Ethnic minority women have more difficulty accessing understandable information on benefits, services and childcare provision. Women from ethnic and other minority communities are particularly vulnerable to mental illness, with women of Asian descent having higher suicide and self-harm rates	BME women.	Women Living in Disadvantaged Communities: Barriers to Participation, Dr Helen McLaughlin on behalf of the Women's Centres Regional Partnership. NICEM's 2006 Report	- 2006
Lone parents and women that have arrived with partners can experience depression, post-natal depression, feelings of isolation, racial harassment, trauma in leaving their families in their home country, high levels of anxiety and stress among asylum seekers who have cases going on for long periods.	BME lone parents.	Women living in Disadvantaged Communities: Barriers to Participation, Dr Helen McLaughlin on behalf of the Women's Centres Regional Partnership NICEM's 2006 Report	 2006
Domestic Violence: due to lack of access to public funds, women are having to choose between	Those without recourse to public funds experiencing domestic abuse.	No Home from Home, NIHRC	2009

- living in destitution; - or returning to abusive relationships; - or returning to their home country.			
% of all single parents: White: 87.1, Black or Black British: 6.8 Asian or Asian British: 3.3, Mixed: 1.2 Chinese: 0.2 Other: 1.4	White single parents.	Office for National Statistics	2006

POTENTIAL SOLUTIONS WHERE OFFERED at regional or local level

NB: these are listed over and above the potential for legislative change

- Flexible Working - Bereavement Counselling - Training for Managers - Provision of CAB - Offer of Creche facilities or childcare - Childcare vouchers - Staffcare - Trade Unions - Summer Schemes - Career Progression Programmes - Offer of flexible service provision - Childcare vouchers - Offer of support mechanisms - Diversity training - Training for Managers - Acute Mental Health Services - Befriending Services - Addiction Services - Work with NIHE, Housing Association - HYPE Project - Cross sectoral working	- Paternity Leave - School Nurses - Maternity Leave - Respite facilities - Suicide Prevention Strategy - Working with Diversity Website - Development of appropriate acute mental health provision - Community Outreach - Accessible information - Parenting classes - Include in training for staff/social workers/Health Visitors - Health Promotion - Work with Learning Disability services - Sex Education - Health Visitors - Work with Community Groups - Research to gain further information

HSC Audit of inequalities: Emerging Themes: Dependent Status

The material presented here provides a brief summary only of the issues facing carers and those with dependants. This section needs to be read in conjunction with the more detailed section on carers and dependants as it represents a brief selection of some of the key issues. Other equally important issues are identified in the more detailed section, available from the Equality Unit of your organisation.

Note: An "exploration of the literature and other materials relating to carers and those with dependants" is a more appropriate term for the activity undertaken rather than referring to a detailed literature review which would require a more thorough and academically driven exercise.

What are the Equality/ Inequality Issues?	Potential solutions where these are offered in the literature Policy/Practice Issues?	Source of Evidence	Date
General Issues			
Caring occurs across all groups in society. Particular issues emerge because of, for example, carers' ethnicity, financial position, their health status, and their caring relationships. Despite this diversity carers want the same thing, sensitive, tailored support designed with their personal and work life needs, circumstances and their values and beliefs in mind. Despite developments carers still have limited recognition in their own right and rather are seen as a resource to older and disabled people. Carers are themselves twice as likely to be permanently sick and disabled.	A social contract for care which places the care given by family, friends at its centre but on that recognition of the shared obligation on public authorities to put in place an effective and integrated infrastructure of local support. Local support that upholds a set of core values ethics and beliefs, and accords carers the dignity and respect and all agencies recognising and including carers.	Carers, employment and services: time for a social contract - Report Number 6 University of Leeds, Yeandle and Buckner A picture of caring. Carers' stories, Carers NI and Equality Commission Report as part of Carers Week 2010 Carer's employment and services : why we need a social contract for care Professor Sue Yeandle, University of Leeds Carers NI Conference	2007 2010 2010

In Northern Ireland there are 185,000 carers. 150 663 of these carers are people of working age. The value of carers' unpaid work in Northern Ireland is £3.3 billion. Carers save the government thousands of pounds per year. The main carers' benefit is worth just £53.90 for a minimum of 35 hours per week which equals £7.50 per day.			
Employment Issues			
In a typical workforce 1:9 male workers and 1:7 female workers are already looking after someone who is sick, disabled or frail. Men who are in paid employment are more likely to be caring for a spouse or partner and women more likely to be caring for a disabled child or an older person. Women who are working part time are more likely to report that they are struggling financially to make ends meet. Currently 1:5 people (majority women) give up work to care. Many find it difficult to re enter the employment field because of difficulties finding a way to combine work and care. This is a major financial loss to the	Underlying the social contract for care must be a set of legal and fiscal frameworks which the state has a responsibility to put in place. These frameworks must guarantee carers the right to equal treatment and protect them from discrimination and social exclusion. It should create a financially secure environment which enables care to be given without asking carers to pay the unacceptable price of low income or poverty in return. It should respect the dignity of carers. Sound equalities legislation is required to challenge discrimination. See also the "discrimination by association" case law as evident in the	Carers, employment and services: time for a social contract - Report Number 6 University of Leeds, Yeandle and Buckner Tipping point for care. Time for a new social contract Carers UK Background to Coleman Case, Carers NI	2007 2010 2008

individual and to the organisation. Women in paid employment are more likely to work from home or close to home. Carers are clustered in lower paid jobs and are less well qualified than other employees. The evidence base of carers in the workforce needs to be radically improved to ensure that carers get a fairer distribution of resources and services.	Coleman Case. Carers should have access to one-one-one support from employment services which recognises complexity of their situation without the threat of punitive sanctions which can add to their stress.	Real change not short change. Time to deliver for carers, Carers UK	2007
Section 75 of the Northern Ireland Act 1998			
General			
In Northern Ireland unlike any other Section 75 Equality Category no other legal protection exists for carers. The diversity of carers is evident across the section 75 equality categories.	Direct and sustained Government interventions. Sound equalities legislation required which challenges discrimination.	Carers NI Effectiveness of Section 75 The Equality Bill and Carers, Carers UK	2007 2009
Age			
Young carers who are adults aged 16- 24 have particular needs. This is a hidden and neglected group of carers.	Young carers' projects and adult carers need to consider how to provide seamless services to this group of carers. This is important for after they reach 18 years. Needs to be more evidence in carers' strategies of young adult carers.	Young Adult Carers in the UK. Experiences, Needs and Services for Carers aged 16-24 Years, Saul Becker and Fiona Becker	2008
Gender			
Women have a 50:50 chance of providing care by the time they are 50. Men have this chance by the time they are 74. In Northern Ireland 62% of carers are female		A picture of caring. Carers' stories, Equality Commission and Carers Northern Ireland As part of Carers Week 2010	2010

and 42% are male. Male carers in the workplace are more likely to care for a spouse or partner. Women are caring for those with additional needs in additional to the usual family caring responsibilities. Different needs for services exist for male carers as for female carers.			
There is a dearth of information on the needs of fathers who care for their disabled children including fathers from black and minority ethnic groups and single fathers. There is an inadequacy in service knowledge based practice within adults' services and children's services relating to groups of disabled parents. As parents get older there is evidence that the caring role gets reversed. Parents with a learning disability are least likely to have access to accessible information about services and support.	Examination of the potential to redress the gap in policy and research with regard to the specific needs of fathers with caring responsibilities.	SCARE Briefing, Social Care Institute For Excellence	2005
Disability			
There is an inadequacy in service knowledge based practice within adults' services and children's services relating to groups of disabled parents.	More research is needed on groups of disabled adults who care, particularly adults with learning disability who care for their children or who care for older parents.	Supporting disabled parents and parents with additional needs. Review number 11, Social Care Institute of Excellence	2006

More research is needed on groups of disabled adults who care, particularly adults with learning disability who care for their children or who care for older parents. As parents get older there is evidence that the caring role gets reversed. Parents with a learning disability are least likely to have access to accessible information about services and support. Negative attitudes or anticipation of negative attitudes can act as a barrier to people seeking support from social services. Parents with mental health problems, drug or alcohol or learning disabilities are reluctant to seek help for fear of having their children taken into care. The secrecy of drug and alcohol misuse can mean that parents are not getting the support they need or and some children may be living in risk situations. There is also a stigma attached to HIV and Aids. This can mean that parents are reluctant to seek or say why they need support. Parents with learning disability and other disabilities least likely to have information provided in a way that meets their particular needs.	Needs arising from impairment and illness and other disabling barriers should be addressed before making judgements about parenting capacity. Accessibility issues in provision of information need to be considered	Working together to support disabled parents, Social Care Institute of Excellence	2007
Sexual Orientation			

Networks and communities can be a useful resource for lesbian, gay and bisexual carers useful for emotional and practical support. However evidence suggests that existing networks cannot always be relied upon and additionally there may be unequal access to these networks. Carers fear prejudice from service providers, service users or from other carers.	More research into aspects of caring by gay, lesbian and bisexual people should be undertaken.	Report on Research about LGBT (Lesbian, Gay ,Bisexual and Transexual Carers) Count me in too, Nick McGlynn , Leela Baski and Kath Brown	2010
Black and Minority Ethnic Groups			
Employed people both men and women in the Pakistani, Bangladeshi and Indian communities have particularly high rates of caring. Younger Pakistani and Bangladeshi men are three times more likely than white British men to be carers and among younger Bangladeshi. Overall the age profile differs between the Black and Minority Ethnic Carers where there is mostly a younger profile when compared with the white population. Socio economic factors impact on minority ethnic carers who on average have relatively low incomes not least because of the younger age profile.	Minority ethnic carers linked to gender and age. More research may be needed in relation to Northern Ireland.	Who Carers Win: The social and business benefits of supporting working carers, ACE National; Action for Carers; Yeandle, Bennett, Buckner, Shipton and Suokas Diversity in Caring. Towards equality for carers, Yeandle, Bennett, Buckner, Fry and Price, University of Leeds	2006 2007

HSC Audit of inequalities: Emerging Themes: Disability

Within the health and social care field, much work has already been done to promote equality of opportunity amongst disabled people, through the continued implementation of the Disability Discrimination Act 1995, Section 75 of the Northern Ireland Act 1998 and the new "Disability Duties". However, ongoing engagement with representative groups and examination of key research and reports has indentified the following emerging themes. The ongoing engagement with representative groups has included RNIB, RNID, BDA, Disability Action, Employers Forum on Disability NI, Disability Advisory Service, Mencap, NI Union of Supported Employment.

What are the Equality/ Inequality Issues?	Potential solutions where these are offered in the literature Policy/Practice Issues?	Source of Evidence	Date
For Service Users			
People with mental ill health viewed most negatively compared with physical or learning disability, resulting in people with mental ill health being particularly vulnerable and isolated.	Effective implementation of Module 4 of Discovering Diversity and Regional Disability Etiquette Guide	HSSPS Literature Review Equality Awareness Survey, ECNI Bamford Review Equality Commission Conference – Key Inequalities O	2008 October 2007
Disabled women have particular difficulty accessing key service such as productive health care and screening		Statement of Inequalities NI ECNI	2007
Disabled people continue to be confronted by real obstacles to participation in society …people with mental health difficulties are particularly vulnerable and can face isolation.		Mr B Collins Keynote Speech at ECNI Annual Conference	2007
Deaf community's need for improved communication.	Establish a working group to develop a regional sign language interpreting service - modelled on the good practice evidenced from the HSC Regional Interpreting	HSSPS Literature Review Access to Public Services for Deaf Sign Language Users	2001 and 2004

	Service (for minority language users). DAP Communication Workstream to develop regional guidelines on accessible appointment processes.	(RNID and BDA) Ongoing feedback from deaf community through DAP Communication Workstream	
Both BDA and RNID receive feedback and complaints from members of the sign language community on a regular basis on access issues and past research carried out by Deaf organisations has pointed to the need for improved access to public services. For example, 77% of BSL users who had visited hospital could not easily communicate with NHS staff and 49% of Deaf and hard of hearing people who had used Jobcentre Plus found that staff were not Deaf Aware.	Frontline health professionals to receive Deaf Awareness training. The installation of visual display alerts in GP and hospital waiting rooms to notify patients of their name being called was recommended. The use of a pager system in a hospital setting should be explored – the Deaf person is given a pager upon arriving and when their appointment is called they are notified by a vibrating pager.	Access to Public Services for Deaf Sign Language Users (RNID and BDA)	2009
Across NI the Deaf community identified very similar issues, with health and employment being the main focus, followed by transport, benefits and services such as rates and council services. Two key problems emerged: the current lack of fully qualified sign language interpreters to provide communication support to enable people to access public services, and attitudinal barriers.	Health service providers to provide alternative methods of making contact, to include text messaging, email and fax and for these details to be promoted to patients. Also to provide an option to book an appointment by email.	Access to Public Services for Deaf Sign Language Users (RNID and BDA)	2009
Access to interpreting services for health related appointments – some Deaf people unaware of their rights under DDA which entitles them to communication support.	All interpreters used by the Health Service should be fully qualified and registered. Staff need to be aware of how to book interpreters, suggest a poster for frontline	Access to Public Services for Deaf Sign Language Users (RNID and BDA)	2009

Degree of confusion as to the role and remit of an interpreter as to whether they can be used to carry out related activities within the same booking period e.g. accompany to chemist for prescription after GP appointment. Some health service depts say they do not have the funds to pay for interpretation costs or that the healthcare professionals are unaware that an interpreting contract exists in their area. Current lack of interpreters in NI makes to difficult to book one at short notice/in an emergency. Also difficult during GP home visits if no interpreter is made available and therefore often rely on family members.	staff (flowcharts have been distributed within Southern Trust and 12 training sessions are running in June 2010). Perhaps Deaf people themselves should book the interpreter for a time that suits them. Staff in hospitals should have level 1 in BSL and wear a badge to alert Deaf people to this capacity. Interpreters should be booked in advance of doctor's appointments and appointment times for all health professionals should be extended by 20-30 minutes for Deaf patients. RNID's out-of-hours interpreter service should be promoted through information booklets. Awareness leaflets for Deaf community re. rights to interpreting support should be developed.		
Communicating with Sensory Disability Social Workers – Deaf people felt, in some areas, that social workers for sensory disability have variable signing skills with some only having Level 1 in BSL which is not adequate for the level of clear and fluent communication required.	Social Workers for Deaf people to be trained to Level 3 in BSL (Social Services Inspectorate to be informed of this).	Access to Public Services for Deaf Sign Language Users (RNID and BDA)	2009
Access to Emergency Services – while many Deaf people were aware of the emergency SMS service to contact the PSNI they were unaware that this also extends to the NIAS and NIF&RS. Were also unaware that NIF&RS can carry out fire safety checks in their homes to identify risk, particularly if household is deemed	RNID, BDA and emergency services to work together to produce an information leaflet for the Deaf community on how to access the PSNI, NIAS and NIF&RS using the SMS emergency number.	Access to Public Services for Deaf Sign Language Users (RNID and BDA)	2009

vulnerable. Again issue of accessing communication support in an emergency was highlighted e.g. in the event of a road accident or a fire.			
General Health Issues – great deal of health related information is not imparted to members of the Deaf community in a fair and effective way. Intercom systems are not accessible to Deaf people. Hospitals do not supply an alerter system for Deaf mothers on the maternity ward – a Deaf woman had to bring her own equipment form home.	Trust websites should offer a plain English option and link to BSL and ISL version. Opticians need to provide a cue card of the alphabet for Deaf clients to point to. Need to increase the number of communicator/guides for Deaf people with Ushers Syndrome (common syndrome that affects both hearing and vision). Staff in audiology services have variable signing skills, clinics are not always accessible with staff calling out patient's names. An audit of signing capacity needs to be undertaken and programme of appropriate training put in place. The Deaf community generally lack understanding about the importance of healthy lifestyles due to inaccessible information and suggest that information is made available via leaflets, signed DVDs, or an accessible A-Z guide on healthy living and relevant resources.	Access to Public Services for Deaf Sign Language Users (RNID and BDA)	2009
Lack of accessible information on available services.	DAP Communication Workstream and Accessible Formats Groups to develop comprehensive guidelines on accessible information for disabled people.	HSSPS Literature Review Access to Public Services for Deaf Sign Language Users (RNID and BDA) Feedback from DAP Communication Workstream	2001 and 2004

Lack of available information for parents regarding child's disability.	Develop information base for all HSC websites on wide range of disabilities.	HSSPS Literature Review	2001 and 2004
High rates of mental ill health among LGBT service users.	Work in partnership through the Regional Sexual Orientation Working Group to improve specific training and development for health and social care staff.	HSSPS Literature Review Regional Sexual Orientation Working Group	2001 and 2004
Access to transport is highly relevant to Health Inequality for Disabled People ... they are less likely to have access to a car than other households. This has a particularly profound effect on those living in rural areas.	Take this into account when planning services.	ECNI Statement on Key Inequalities in Northern Ireland WHSCT Audit of Sensory Support Services for People with Hearing Impairment	2007 2010
Inappropriate communication support for people with Learning Disability when accessing GP and Acute Services.	Be more proactive in this area	ECNI Investigation into Accessibility of Health Information in Northern Ireland for People with a Learning Disability	2007
Inappropriate Communication Support for people with hearing impairment. Lack of availability of sign language interpreters or absence of up to date loop systems.	Sign Language interpreting training for key staff. Keep up to date aids and equipment	WHSCT Audit of Sensory Support Services for People with Hearing Impairment	2010
Under representation of disabled people in current workforce.	All health and social care organisations to approve and implement the Regional Framework on the Employment of Disabled People.	ECNI Survey re Public Attitudes to Disability in Northern Ireland Health and Social Care workforce monitoring Evidence gathered through DAP consultation processes Equality Commission Conference – Key Inequalities	2001 October 2007
Roughly two thirds of respondents did not believe that employers do enough to meet the needs of disabled people		ECNI Survey re Public Attitudes to Disability in Northern Ireland	2001

Most respondents disagreed that there is a fair representation of disabled people in more senior jobs.		ECNI Survey re Public Attitudes to Disability in Northern Ireland	2001
The employment rate for those without disabilities (79%) is over twice that of people with disabilities (32%)		Mr B Collins Keynote Speech at ECNI Annual Conference	2007
Although almost one in five persons (18%) of working-age are disabled in NI, in 2006 only 3% of appointees to government public appointments were disabled.		Mr B Collins Keynote Speech at ECNI Annual Conference	2007
Around 60% of those who become ill or disabled were in employment a year before onset of disability, which then fell to about 46% in the year of onset of the illness or disability, with the employment rate falling again one year after onset of illness/disability to approx. 40%.		The Dynamics of Disability and Social Inclusion, Brenda Gannon and Brian Nolan, Equality Authority and National Disability Authority, ROI (taken from the Living in Ireland Surveys 1995 to 2001)	1995 - 2001
Lack of understanding of disability and diversity and multiple identity – access problems may be specific to certain types of disability e.g. learning disabilities, mental illness. The inability of health and social care providers to recognise the heterogeneity of people with disabilities often has a profound effect on the capacity of people with disabilities to access appropriate health and social services. Negative attitudes towards the person with the disability. Undeniably the HPSS have through their S75 duties made significant progress towards	Education for staff to recognise the diverse needs of people with disabilities – renewed emphasis on disability awareness training. Involve people with a disability in the designing and service delivery – identify models of good practice – encourage membership of self-advocacy groups for persons with a learning disability in order to develop their self-confidence and their skills to talk and be listened to. Lack of clear, consistent and comprehensive information on the prevalence of disability in NI – the collation of detailed information is crucial in order to identify areas of	HSSPS Literature Review	2001 and 2004

creating equality in access to health & social services for people with disabilities	inequality and needs and to target services accordingly.		
Lack of wheelchair access – lack of information on available services - lack of information in alternative formats e.g. Braille, audio cassettes and pictorial for people with a learning disability. lack of adaptations and equipment on the grounds of cost – inconsistencies in level of support e.g. less support for people with mental health difficulties. Inadequate transport to and from health care facilities – lack of consultation on policy and decision making. Inadequate information, advice and support on sexual health and reproduction – assumptions that disabled people are not sexually active – denied access to appropriate sexual health services e.g. cervical screening, information on sexually transmitted diseases, family planning services etc. Lack of sex education within day centres and special schools – inadequate access to services. Lack of ramp, inaccessible treatment rooms, toilet facilities, large print signs. Lack of advice in appropriate formats e.g. for people with a learning disability. Potential abuse of vulnerable adults, children and young people due to lack of knowledge and information – information for those who acquire a disability during their lifetime.	The HPSS should conduct a study and needs assessment in co-operation with Disability groups – design and deliver specific audience sex education and health programmes for people with disabilities to be delivered in special schools, day centres, health centres etc. – design and promote a range of materials on sexual health and disability in a range of formats with information on how and where to access appropriate services or further advice.	HSSPS Literature Review	2001 and 2004
Issues relating to learning disability:	Review of day centres and assessment of	HSSPS Literature Review	2001 and

Attitudes of others about their ability to participate and contribute to policy making and decision making. Absence of information in alternative formats. Need to support people during and after participation. Lack of transport which prevents participation. Limited range of activities available in day centres – should involve mixing with non disabled people also. Embarrassment of marked transport to and from centres – transport problems of rural areas, Reduction of number of available places in day centres. Lack of information to make informed choices. Particular doctors not listening to their wishes about medication. Inaccessibility of accident and emergency procedures e.g. too long a wait for appointment, fear of blood, noise and crowds. Lack of advocacy and support to include people with learning difficulties into the economic and social life of the community. People with learning disabilities more likely to experience weight problems both obesity and low weight. Inadequate levels of funding for therapy services such as speech and language therapy, physiotherapy and occupational therapy.	activities provided. Review the accessibility of A&E and information in a range of formats e.g. Braille, large print, audio cassette and plain English etc. Encourage a culture of volunteering to support their inclusion into the community Develop healthy living packs in accessible formats tailored to meet the needs of both children and adults with a learning disability. Involving partnership with persons with a learning disability their families and carers in the planning and implementation. HPSS should work in partnership with people with learning disabilities their families and carers to develop a range of support living and leisure opportunities.		2004
Mental Health Issues – services are not designed around the needs of the service user. Psychiatric services are often in non-therapeutic environments and negative ward environments. Lack of	Ensure service users are involved at all levels of decision making including planning of services. Admission to hospital should be last resort, effective community based alternatives should be explored.	HSSPS Literature Review	2001 and 2004

access to crisis intervention services and multi-disciplinary community based support. Lack of access to relevant information, diagnosis, treatment options, access to services, admissions, discharge, accommodation, benefits. Lack of access to mental health services for children and adolescences. Lack of access to appropriate support for victims of violence in NI.	Access to appropriate information to make informed choices, targeted at people with mental health problems. Complaints procedure must be accessible. Develop specialist mental health services specifically targeted at children and young people.		
NI is increasingly becoming a multi-ethnic society which includes Travellers, Migrant Workers, Asylum Seekers and Refugees – disabled people from these groups are largely invisible. Disabled people are often presented as a homogeneous group and therefore ethnic and other differences are largely ignored - there is a tendency to perceive asylum seekers and refugees as able bodied. Many disabled people from BME groups are unaware of services available to them – inability to meet and interact with other BME disabled people – stigmatisation of disability within some BME groups may prevent disabled person from participating in society. Some BME families reluctant to access services believing the care of the disabled person was a family responsibility. Many reluctant to access health & social services due to fear, suspicion or distrust from past experiences in other countries (particularly asylum seekers and	HPSS in co-operation with disability groups and BME groups should commission a needs assessment and research and identify the health and social care needs of disabled persons from BME communities. Work to establish BME disabled groups in NI and refer clients to these groups for support and advice. Build a relationship of trust with BME disabled persons to encourage them to access services they require. Produce information packs and a media campaign in alternative formats. Conduct regular collection of data in order to plan and monitor service delivery.	HSSPS Literature Review	2001 and 2004

refugees). Asian people less assertive in accessing services, less likely to complain and less likely to reapply when service is initially denied.			
Children and Young People with a disability – parents lack of knowledge regarding their child's disability or condition. Parental relationship strain and family breakdown – social isolation for children, young people and their parents – additional expense regarding special diets, clothing, equipment. Adaptations - more modern alternatives requested. Undue effort involved in obtaining appropriate services – access to services complicated. Services provided across different programmes of care. Need for more flexible, comprehensive and family based respite services focused on the needs and wishes of disabled children and young people.	Promote independent living. Conduct a needs assessment regarding domestic assistance to parents and carer's. Consultation with children and young people themselves to ensure services are acceptable to them. Develop robust information systems and registers to facilitate adequate assessment and planning of needs. Develop an information base, websites, information packs on a wide range of disabilities and impairments for parents and carer's. Assessment of needs and support for parents of newly diagnosed children with disability or impairment.	HSSPS Literature Review	2001 and 2004
"Coming out" to health and social care professionals is even harder for disabled people. Lack of understanding of health and social care staff. Lack of access to appropriate sexual health advice. Profound social isolation of LGBT disabled people living in residential accommodation	Improved training and development for staff to understand the experiences of LGBT disabled people. Provision of concise information. Support the capacity of grass roots networking organisation to bring together LGBT disabled people in order to identify and address their difficulties including the problem of social exclusion.	HSSPS Literature Review	2001 and 2004
Disabled women are more likely to have	Health promotion campaign specifically	HSSPS Literature Review	2001 and

low levels of physical activity than non disabled women – obesity is a significant problem. Little known about effects of menopause or the treatment of its symptoms on disabling chronic conditions. Lack of information on fertility problems. Less likely to receive information on sexual and reproductive health. Assumptions by health care providers that they are not sexually active. Less likely to receive breast or cervical cancer screening.	targeted at disabled men and women focusing on encouraging an increase in appropriate physical activities and addressing the problems of obesity. Create information packs, leaflets, web pages providing concise information including information on services on disability and the menopause. Conduct a needs assessment of disabled women in relation to gynaecological and obstetric care. Review pre and post natal care and identify areas for improvement.		2004
People with a learning disability and people with mental health problems need to have a say about the services they get. Their families and carers need to be part of this.	People must get the information they need to have choice and control in their lives. Involving people must be part of everything we do in health and social care services.	Bamford Review	2007
Health and Social Services Board and Health and Social Care Trusts need to have a way of asking people what they want. They need to have services that are local and meet people's needs. Services need to fit around people, not people fitting into a service because that is all there is in their area.	Health and social care services need to be reorganised to make sure this happens. In each region there will be someone who is responsible for making sure that services are set up in a way that works well for the people who will use them.	Bamford Review	2007
Poor communication between healthcare staff and people with a learning disability. A lack of understanding of the health needs of people with a learning disability. A lack of relevant written information provided in an accessible format.	A strategic approach to the development of a range of accessible written health information should be adopted and led by the DHSSPS. This will require: A standardised DHSSPS policy and procedure for producing and distributing	ECNI Formal Investigation into The Accessibility of Health Information in Northern Ireland for People with a Learning Disability	2007

	written information which is accessible for people with a learning disability. Identification of priority areas of health information important to people with a learning disability. The development of an easily accessed central source for all such information. The development of a systematic approach to ensure that people with a learning disability and their representative organisations are involved from the beginning of the process of preparing such accessible information. Development of a specifically tailored appointment letter across the Health and Social Care Service for use when inviting a person with a learning disability to a medical appointment. In addition, consideration should be given to providing the person with further accessible information about the service when appointments are made. A passport system be developed to give people with a learning disability the option to identify their particular communication needs when accessing health services.		

HSC Audit of inequalities: Emerging Themes: Ethnicity

The following issues have been extracted from the Compendium of Race Health Inequalities prepared by the Southern Trust over the past 5 years of years. This Compendium listed recommendations from over 60 research documents and pre consultation took place in October 2010 with the following organisations: NICEM, Craigavon Intercultural Programme, Traveller Safe and Well Project, Wah Hep, Craigavon Women's Muslim Association, Newry and Mourne Ethnic Support Centre, STEP and Challenge of Change.

What are the Equality/ Inequality Issues?	Potential solutions where these are offered in the literature Policy/Practice Issues?	Source of Evidence	Date
A. For Service users. *It has been reported that MW's arrive in the UK with relatively good health which tends to deteriorate over time. Many of the health issues faced by MW's can be viewed as symptoms of poverty, poor access to services, work related issues, poor accommodation and dietary changes. Source: The Health of BME (Kings Fund London).* **The majority of the issues below are also found in the NICEM Report 'Black and Minority Health and Wellbeing Development Project for North and West Belfast' September 2006.**			
Eligibility and Access to Services: **GP Registration** - unfamiliarity with system - employers not letting time off to register - GP quotas for MW's - **attitudes of frontline staff** - MW's are a 'burden' - insensitivity to cultural needs - stereotyping - patronising attitudes - **low registration with Dental services**. **Medication instructions not translated** Lack of clear explanation of what is happening during medical examinations. GP receptionists act as barriers to some services. **Challenging the role of Receptionists** within GP surgeries. Currently they	**Specialist services** needed to meet the needs of specific ethnic groups. Ensure that all management development training programmes include **cultural diversity training**. **Long term training** to ensure medical staff are culturally competent. **Training on cultural nuances** for all primary care staff to include GP's, Receptionists, Nurses and Health Visitors. Regular specific surgeries with a **bi lingual health professiona**l in attendance.	ANIMATE OFMDFM Race Strategy 2005-2010 OFMDFM 'A Shared Future' 'Life as a Stranger' - The personal stories of Migrants to NI (Zachlebem) NICEM 2009 'New to NI' - A study of the issues faced by migrant, asylum seeking and refugee children in	2007 Sept 2010 2009 October 2010

appear to be gatekeepers for access to certain services such as Interpreters. **More flexibility in the use of Interpreters**, they should not be restricted to when clinicians feel they are necessary, but should be offered as a matter of course. It was noted on numerous occasions that children should not be used as Interpreters. Lack of understanding or facilities for people whose culture dictates that their newborn sons should undergo **circumcision**. Often it's not done immediately due to red tape etc. and the child ends up being circumcised when older, causing much distress to the child.	**Adequate Resourcing:** The telephone interpreting service is of very limited use where house calls are concerned, yet budgetary constraints do not allow for widespread face to face interpreting. **Funeral rites**: Body to be treated according to their religion/culture.	NI BME CERD Framework Convention on the Elimination of Racial Discrimination Working Group	February 2010
Language and Communication Barriers: Concerns about potential misdiagnosis and confidentiality - unaware of the availability of **interpreting and translation services** - consent issues. Receiving letters detailing **appointments in English** is problematic resulting in people missing appointments.	There should be a more **proactive approach in targeting materials** to BME groups e.g. community newsletters, language broadcasts, materials placed in areas frequented by BME people such as supermarkets, cafes, workplaces and places of worship.	A Study of MW's in Scotland (Zachlebem) NICEM 2009 The Health of BME (Kings Fund London) 'Ethnicity, Equality and Human Rights: Access to H&SS in NI' Mapping Exercises Down & Lisburn	2009 2006 Oct 2010
Emergency Support - Social Services (There is **no safety net** for undocumented workers – financial assistance in times of dire need) -	Need for **guidance and leadership from DHSSPS** in updating guidance incorporating references to human rights. Restricting access to health to someone on	ANIMATE 'Diverse Dialogue' - Report of the North South Intercultural	2007 2005 - 2008

restrictions on social security benefits for non-EU MW's – homelessness. **Habitual Residence Conditions New Points Based System -** Healthcare professionals unaware of MW's entitlement to services - **lack of clarity on the rights and entitlements of the different categories of MW's**. **Check progress of OFMDFM Crisis fund**.	the basis of their ethnic origin could constitute institutional racism. A key issue exists for those individuals who are here but have **"no recourse to public funds"**. Concerns about foreign nationals who "slip through the safety net" have been around for some time and these concerns are growing. "*Within the context of UK legislation, we are determined to examine what support we can give to people who, through no fault of their own, fall into difficulty"*.	Forum The Health of BME (Kings Fund London) (Zachlebem) NICEM 2009 Programme for Cohesion, Sharing and Integration No Home from Home	 2009 Sept 2010 NIHRC 2009
Mental Health: Culture shock - job insecurity - **isolation** in rural areas particularly among pregnant women - family reunification sometimes very hard - financial insecurity - **stress - reduction in self esteem - take up of mental health services very low** - **suicides** - **self harm**. **Interpreters** cannot act as advocates in counselling sessions. Counsellors said working in sessions with an Interpreter from clients own community led to issues of **confidentiality** Low satisfaction levels among BME comunities	**Counselling services** need to be provided in their own language. **Mental health promotion**. **Establish a directory of services** to enable MW's to access information on health services. **Peer advocacy** or active strategies to employ **bi lingual health professionals in particular MH counsellors**.	ANIMATE The Health of BME (Kings Fund London) www.mind.org.uk Western Health and Well-being Sub Group Race Equality 'Life as a Stranger' - The personal stories of Migrants to NI (Zachlebem) NICEM 2009	2007 Sept 2010 2009
Child Health **Childcare facilities:** Absence of childcare providers operating in hours of	**Ensure childcare provision is inclusive of all children**	ANIMATE 'New to NI' - A study of the	2007 October

shift work - Language skill deficit within the existing provision - **difficulties in recognition of childcare qualifications obtained abroad** - absence of family networks - ineligibility for childcare element for non-EU MW's - **child protection risk issues** - lack of childcare during school holidays. The health of the BME child – growing up in a bilingual/bicultural environment, taking on adult responsibilities, bullying. Access to dental treatment, obesity, low income families resulting in increased health concerns in later life. Gastroenteritis due to living conditions. Childhood obesity – risk of developing diabetes There appears to be a misunderstanding among some professionals as to migrants' eligibility to register with GP's. According to the Law Centre NI "entitlement to free treatment in the health service is not determined by nationality or whether a patient has paid NI contributions – it is based on whether a person is 'ordinarily resident' in NI (2008).	A health visitor reported that on gaining access to a child's home, other issues become apparent such as: • poverty that is the result of the lack of basic provision; • accommodation problems such as significant overcrowding with whole families in one room; • lack of stimulation for younger children at home – they have no toys or books; • teenagers babysitting other children; • children of school age missing school; • children left unattended; • children working underage (busking); • parents failing to attend appointments with their children; • Non registration with GP's is a huge issue for Roma families – they have to pay £50.	issues faced by migrant, asylum seeking and refugee children in NI Pre consultation with Southern area BME Representatives	2010 October 2010
Health and Education practitioners noted the **lack of background information on newcomer children,**	Age assessments and age disputes are a major issue for social services. Being over or under 18 has major implications for the	'New to NI' - A study of the issues faced by migrant, asylum seeking and refugee children in	October 2010

which can make treatment and service provision difficult. For reasons associated with eligibility children from A2 countries Bulgaria and Romania, particularly Roma children, are vulnerable and hence represent a significant challenge to health professionals. Major implications for children's health, including routine health assessments, inoculations, health visiting for newborn and young children as well as ancillary services such as dental treatment or eye tests. Determining a child's age is very difficult if no record exists of their date of birth.	way social services assess and address needs. The loss of extended family networks and friend often result in feelings of isolation. For asylum seeking children, however, the sense of loss was usually more intense in that family members may have actually been killed or may still be living in danger in the country of origin. The asylum seeking process had a negative effect on children's emotional and mental health, with anxiety and a fear of deportation being common. The health needs of the Roma population require special mention, although small, was incredibly complex. Due to increased incidence of TB among Roma children health assessments are necessary but problematic.	NI	
Maternity Services: Lack **of face to face information** when attending maternity services postnatal care - language barrier patients with very limited English - culture shock - **negative attitudes of staff -** lack of information regarding maternity benefits - translated information needed on the menopause, breast cancer, smear tests, family planning, diet, childcare and immunisations. Maternal and infant mortality are higher	**Identify a key worker** in statutory organisations who could be the first point of contact when information is being sought. This would give a human face to public bodies and service to make them more approachable. **Translated health promotion leaflets.** Health promotion needs to be more proactive with this potentially high risk group and they need **greater support and**	'Out of the Shadows' - An action research report into families, racism and exclusion in NI 1997 Ethnic and social inequalities in women's experience of maternity care: Results of a national survey Review of Literature on Equality of Opportunity Issues in Health and Social Services	1997 March 2001

among BME groups. BME women were more likely to access services late e.g. not have a scan by 20 weeks, attend antenatal classes, have a post natal check up and were more likely to experience complications. **Difficult to complain.** **Lack of knowledge of Social Services and its functions.**	**care from maternity services during pregnancy and afterwards**. **Complaints forms in other languages.**		
Older people from BME communities: Often experience higher levels of **isolation in hospitals.**		Realising Integration. MRCI	2006
Institutional Racism - ensure **equality of opportunity** for BME people in assessing and benefiting from all public services. Promote dialogue between and **mutual understanding** of the different faiths and cultural backgrounds. **Build capacity** of BME groups to develop a sustainable BME sector. Increase number of **BME volunteers**. Combat racism and provide effective **protection** and **redress**. Eliminate unlawful racial discrimination and promote equality of opportunity. Need to address **institutional racism** and a clear knowledge of its continued existence.	Training and awareness initiative for policy makers and frontline staff will focus on eliminating the potential of incidents of "unwitting", "unconscious" or "unintentional" racism as well as deliberate and intentional racism. **Focus on those groups who still suffer particular disadvantage**, rather than treating al minority ethnic groups as having the same needs. **Outreach initiatives and devising new and innovative ways of engaging minority ethnic people and involving them**. **Capacity building** - not just with funding but include training, organisational and personal development and resource building. **Target efforts and resources towards**	OFMDFM Race Strategy 2005-2010 'Racism and the Recession' McPherson Report on the Stephen Lawrence Case ECNI Response to OFMDFM Race Strategy Programme for Cohesion, Sharing and Integration (CSI)	2005-2010 Unison 2009 1993 Sept 2010

Strategy needs actions attached to it. To build a society where cultural diversity is embraced and celebrated and to promote pride in who we are and confidence in our different cultural identities.	**those experiencing greatest disadvantage.** **Surveys** to provide a specific focus on minority ethnic people – improving the base line data must be a target		
Health specific issues: Sickle cell disorder - depression - stress - suicide - schizophrenia - diabetes - heart disease - racism - lack of confidence - hepatitis B - HIV - tuberculosis. **TB – non-completion of treatment** **Substance abuse – addiction – isolation – depression -** limited access to rehabilitation centres and educational programmes **Low awareness and uptake of Respite Services:** Asian carers had low awareness and usage of specialist services for people with learning disabilities.	**Be aware of distinctive patterns of ill health.** **Specific BME health promotion policies.** **Additional time required for appointments/consultations.**	'The Health of BME' (Kings Fund London) Review of Literature on Equality of Opportunity Issues in H&SS Netto Ward, 1998 BME Health and Wellbeing Report N&W Belfast. NICEM	March 2001 1998 1998 2009
Trafficking: Women coerced into prostitution – domestic violence – sexual abuse. Sexually transmitted diseases – higher percentage than indigenous communities		'The Health of BME' (Kings Fund London) 'The Nature and Extent of Human Trafficking in NI'. NIHRC	 NIHRC 2009
According to DHSSPS Equalities and Inequalities in Health and SC in NI the 3	**There is an emerging pattern of inequalities experienced by MW's in**	Statement of Key Inequalities in NI. ECNI	October 2007

main determinants of health inequality are related to **socio-economic/ environmental circumstances; lifestyle and health behaviour; and access to effective health or social care**.	**particular unequal access to basic health care. There are significantly poorer levels of health amongst Travellers.**		
Cultural Needs: Provision for prayer and religious observances. **Diet**: halal/kosher meat – customs around death, birth and diet. As well as ethnic origin need to know religious and cultural needs, language needs, advocacy needs, specific health beliefs and use of other health care systems. **Proactive steps need to be taken**.	**Female doctors.** **Increase cultural competency** of staff through cultural awareness training and anti discrimination training. Customise services to meet cultural needs - address dietary requirements - accommodate special customs at times of bereavement and birth.	'Out of the Shadows' - An action research report into families, racism and exclusion in NI A Guide to the main equality in health issues	1997
Travellers: Poor environmental/ accommodation affecting health - lack of recognition of Travellers specific needs - **lack of basic amenities such as water, electricity and sanitation** - **continuity of care** as Travellers are often on the move. Travellers are of particular importance to the ECNI. Crucially the strategy must reduce inequalities that Irish Travellers have experienced for centuries providing greater equality outcomes in key impact areas such as health and education. **Improving life chances for Travellers** will be a critical success factor and a major challenge for government. **Negative attitude towards Travellers particularly in hospital.**	Need to keep the effectiveness of current provision to Travellers under review. See OFMDFM Racial Equality Forum 13 Key Principles Jan 2008. **Lay health Worker for Travellers.** **More health promotion.** More **inter-agency working** to monitor, co-ordinate and facilitate services for Travellers. Work in **partnership** with Traveller support organisations to deliver services. **Develop specialist services e.g. family**	Reeves Associates - Assessing the Impact of S75 Promoting Social Inclusion of Travellers. OFMDFM ECNI Response to NI Race Equality Strategy 'Ethnicity, Equality and Human Rights: Access to Health and Social Services in NI' Western Health and Well-being Sub Group Race Equality 'A Guide to the main equality in	2000

Low mortality rate. **Information not always clear due to low levels of literacy**. Lack of awareness amongst Travellers of preventative health services e.g. immunisation, screening programmes. **Mental health:** Social isolation - stress - uncertain of tenure - not having a proper home overcrowding in confined places - denial of depression often in Traveller men - unemployment - domestic violence. Support and promote the **employment of Travellers in healthcare**. Work with the Travelling community to plan and provide services designed to improve their health and wellbeing. The key health issues for Travellers identified during the consultation process were as follows: • environment and poor living conditions; • issues related to equality of access to, participation in, and outcome of service delivery; • rights of Travellers to appropriate access to services based on culture and way of life; • lifestyle issues; • lack of culturally appropriate	**planning.** **Awareness training for staff.** Culturally appropriate healthcare needs to be provided. **Monitor** the outcomes for Travellers. **Volunteering** opportunities for Travellers. **There are 4 priority health care needs:** **1. mother and child services merit top priority;** **2. men's health issues need to be addressed specifically;** **3. there is a concerted need to address cause-specific issues for respiratory and cardiovascular disease;** **4. priority should be given to a new model of primary care delivery for Travellers dovetailed in the Republic of Ireland with the emergence of Primary, Continuing and Community Care Services, and in partnership with the Primary Healthcare for Travellers Project Networks.** Given their high mortality, likely high incidence, and low appreciation of the risk factors in the community, it is appropriate to mount an opportunistic **cardiovascular disease risk factor detection**	health issues' Southern Area Action for Travellers SAAT All Ireland Traveller Health Study	 Sept 2010

provision; • lack of data on Traveller health and health needs; • lack of recognition of Traveller culture and identity; • individual and institutional level racism; • social exclusion. Some of the key recommendations of the All Ireland Traveller Health Study Report include: • a **strategic Action Plan** should be developed; • adequacy of **accommodation** is essential; • all aspects of **mother and child services** merit top priority; • **men's health issues** need to be addressed specifically; • there is a concerted need to address cause-specific issues for **respiratory and cardiovascular disease**. **Life Expectancy** Traveller male life expectancy now is 61.7 years which is identical to what it was in 1987. This life expectancy in Traveller males is at a similar level to that of the general population in 1945 - 1947 when it was 60.5 years. Traveller female life expectancy has increased from 65.3 years	**programme for Travellers**. Given the mortality findings in the vital statistics sections, particularly for men and in relation to respiratory and cardiovascular disease, it is important also to get **earlier and more active engagement, especially in primary care,** and to address the need for more engagement by Travellers in **preventive services and follow-up**, particularly for management of chronic disease, such as for respiratory and cardiovascular conditions. The poor health of male Travellers documented in our other reports, and the perception that they present particularly late for care, suggest need for **urgent action to engage** with this group of people. **Health promotion skills programmes** must therefore be sensitive and culturally specific, for instance addressing the traditional value placed on salt and butter in the diet, the strict hygiene codes in Traveller kitchens and the limits of cooking equipment in homes. There are negligible numbers of Travellers **over 50** years of age. This is not explained by migration, is not explained by integration into the general population, and not explained by denial of Traveller identity. **The only realistic explanation is of premature death. Suicide rates of both young men and women are high**		

in 1987 to 70.1 years. This is of a similar level to the general population in 1960 – 1962 when it was 71.9 years. For men in particular the mortality pattern is bleak. **Infant mortality rates have deteriorated since 1987.** Traveller infants today are **3.6** times more likely to die than infants in the general population. In 1987 Traveller infants were **2.4** times more likely to die than in the general population.	**and in men many fold higher than their contemporaries in the general population.** **63% of Travellers are under 25 compared with 35% nationally.** **42% of Travellers are under 15 compared with 21% nationally.** **3% of Travellers are over 65 compared with 13% nationally.**		
United Nations Findings last 10 years • **Travellers Rights** • **Violence against women** • **Protection of Religion of Minority Groups** • **Child Poverty** • **Trafficking** • **Participation of vulnerable adults in decisions that affect them** • **Contracting out** – Procurement criteria not just value for money but quality for service users Feedback from the Traveller Awareness Training Programme highlighted some emerging themes: • **Domestic Violence;** • **Sexual Health;** • **Drugs and Alcohol;** • **Mental Health.**		The future of Human Rights in the UK – NIHRC Conference SHSCT Traveller Awareness Training	16.09.10 22.09.10
B. For HSC Staff			
Financial Constraints: Lack of	Need for strategic planning.	The Health of BME (Kings Fund	

resources for interpreting and translations - the need for funding for Interpreting and Translation services was the most pressing issue for service providers.	Predict future trends.	London) A Study of MW's in Scotland	
Influence of folk religion – confidence in herbal treatment	Mixture of herbal treatment and GP prescriptions	Pre consultation with BME representatives	October 2010
Ethnic Monitoring - transient and **ever changing profile** of MW's make it difficult to plan services - some public authorities reported feeling overwhelmed - some services ad hoc and reactive and dependent on the commitment of individual staff - lack of data - **limited or non-existent monitoring** - service providers lacked systematic and coordinated communication routes - **no overall outreach strategy** for providing advice and information about accessing services. A proper system of **ethnic monitoring** will allow service providers to: highlight possible inequalities; investigate their underlying causes; and remove any unfairness or disadvantage. It will let service providers know which groups are using their services and how satisfied they are with them.	**Ethnic monitoring** (the process used to collect, store, and analyse data about people's ethnic backgrounds) by service providers of key areas of service provision is essential to achieve racial equality. **To have a racial equality policy without ethnic monitoring has been likened to aiming for good financial management without keeping financial records.** **Consider ways of reaching under-represented groups** and make sure those services are relevant to their needs and are provided fairly. **Lack of accurate statistics.**	The Health of BME (Kings Fund London) OFMDFM Race Strategy 2005-2010 'New to NI' - A study of the issues faced by migrant, asylum seeking and refugee children in NI	2005-2010 October 2010

Mainstreaming - is the key to ensuring equality of services. Mainstreaming involves the application of equality proofing, guidelines, participation of groups experiencing racism, positive actions, data collection, proactive monitoring and impact assessment. It involves each organisation accepting its own responsibility for promoting racial equality and challenging racism. **Bi-Lingual BME Advocacy Workers –** Social Worker, SW Assistant, Community Development Worker, Family Support Worker, Therapists, Counselors. **Teach staff the language.** **Welcome** differing cultures and minority ethnic groups. The **psychological** needs of refugees and asylum seekers.	**Health priorities identified during consultation:** The need for Traveller specific health strategies The issues and needs of minority ethnic people in the area of **mental health.** **The employment rights and protection from harassment of overseas nurses working in the health sector.** **Low levels of GP registrations.** **Identify any gaps in information and service provision and produce an Action Plan which will address immediate, medium and long term needs.**	OFMDFM Race Strategy 2005-2010 Audit of Unmet need Armagh & Dungannon area Programme for Cohesion, Sharing and Integration (CSI)	2005-2010 April 2007 September 2010
Employment: Lack of recognition of qualifications obtained abroad - low levels of English - MW's tend to be working in occupations well below their actual level of skills and experience - working conditions **- health and safety issues** leading to higher mechanical injuries, environmental and infectious diseases, pesticide exposure and social and psychological problems - lack of awareness of employment rights - fear of asserting rights - control issues with employers	To avoid discriminating against migrant workers, employers should not simply specify that candidates must have qualifications that can only be obtained in UK educational systems (e.g. GCSE's or A-Levels). Employers should have a procedure for evaluating the comparative value of qualifications gained overseas with those gained	The Health of BME (Kings Fund London) 'A Unified Guide to Promoting Equal Opportunities in Employment'. ECNI 'Life as a Stranger' - The personal stories of Migrant Workers to NI (Zachlebem)	 March 2009 Sept 2010 2009

- exploitation - long hours, low pay - job insecurity - restrictive contracts and refusal of employers to honour entitlements including holiday and sick pay - English language classes - banking services - internet access. **Employment is a key driver of economic and social wellbeing and presents one of the key routes to social mobility and inclusion. Health and social care is fundamental to a person's quality of life and well-being.** **Immigration rules:** Employers must comply with immigration laws. For example, it is unlawful for an employer to employ a person who is subject to immigration control, unless that person has current and valid permission to be in the United Kingdom, and has valid permission to do the type of work on offer.	in the UK. Employers can obtain advice on these matters from any of the following: • **Council for the Curriculum, Examination and Assessment: www.ccea.org.uk** • **UK National Recognition Information Centre www.naric.org.uk** • **UK National Reference Point: www.uknrp.org.uk** The Border and Immigration Agency is the public authority responsible for enforcing the immigration laws and is the best source of information and guidance about them.	NICEM 'Racism and the Recession'. Unison Statement of Key Inequalities in NI. ECNI **Border & Immigration Agency's website: www.bia.homeoffice.gov.uk**	 2009 October 2007
Establish **multi-agency partnerships** between indigenous and minority ethic and migrant worker communities to address the specific needs of the young people in those populations. E.g. C&B Interagency Migrant Workers Support Group and the Southern Area Race Equality Forum.	A Ministerial Panel chaired by OFMDFM, Ministers, key statutory and community partners A Senior Officials Steering Group An Advisory Panel A Funders Group OFMDFM	Programme for Cohesion, Sharing and Integration (CSI) ***Promoting respect** for newcomers, Irish Travellers and children from the Roma community is a particular priority for OFMDFM*	September 2010
Procurement: The Central Procurement Directorate within the Department of Personnel includes an **equality clause** which places the onus on suppliers to meet obligations under S75. The CPD also continues to work with the Construction Industry Forum NI to bring forward proposals that address the issue of Migrant Workers to **ensure their fair**		Programme of Cohesion, Sharing and Integration	September 2010

treatment.			
Professionals involved in front line services felt that there was a **lack of clear guidance and policies** in place. Different interpretation or application of guidance leading to uncoordinated practice. Strategic leadership is required to influence policy development and oversee effective planning of services. There is a need for an information hub, to map existing resources, offer a signposting service, collate evidence of good practice, be alert to emerging trends and support the implementation of strategic plans. A network of practitioners should be developed. This network would include all practitioners from the public and voluntary sector who work with migrant, asylum seeking or refugee children and would encourage information sharing, confidence building and advocacy. The network would also encourage cross-sectoral working by building relationships and good practice. Barriers may be created by the prejudice of some working within health and social care organisations and by a lack of unwillingness on behalf of service providers to facilitate access to services. (Animate and others, 2007). This is particularly the case regarding access	Front line workers felt that they could only have a limited impact if their organisation did not provide strategic leadership. **Interagency work vital to meet the needs.** Every practitioner noted their concern and their need for improved levels of information and resources. Diversity and cultural awareness training is required focusing on these groups of children. An interim co-ordinator should be appointed, to lead on the implementation of the recommendations. There is a need for greater awareness among migrant populations of their right to health and social care services and how to gain access to them. (SHSSB/NICEM/NHSSB 2007) Similar barriers as well as institutional racism have also been highlighted by ECNI and DHSSPS in the Racial Equality in Health Good Practice Guide 2002.	'New to NI' - A study of the issues faced by migrant, asylum seeking and refugee children in NI	October 2010

to primary healthcare, meaning that children from migrant families are not registered with a GP. These problems are exacerbated by issues such as communication difficulties and the lack of correct documents required for registration. (ECNI, 2009). The increased risk of mental illness among child asylum seekers in NI has been highlighted by NICCY 2008. The lack of expertise among primary care and social care staff in identifying the severe mental health difficulties experienced by some asylum seeking children. (Chase and other, 2008). Health Visitors in the SHSCT identified children from over 60 countries. They also identified the following barriers that may prevent the parents of such children from accessing health services: • language difficulties; • families are mobile and have no permanent address; • heightened expectations of service; • lack of awareness of how to access GP services and so access A&E services; • lack of confidence accessing child health clinics and mother and toddler groups; • low levels of car ownership; • lack of current localised information on services in specific languages; • social isolation and missing extended family support.	In 2007 NHSSB and NICEM recommended the establishment of **tailored family support services for migrant families and the necessity to address the issue of GP registration**. For Trust workers this has meant that working with these families is resource intensive in terms of health professional's time e.g. arranging interpreters, more frequent home visits and more time spent arranging appointments. Cultural issues were identified that potentially inhibit access and uptake of services e.g. weaning and feeding practices, child rearing practices. Post natal depression and social isolation are a particular issue for mothers while speech and language needs, developmental concerns and child protection issues for children.		
Policy and Planning: How the organisation	1. Senior managers lead the	Race Equality Audit for NI. NICEM	2004

formulates, deploys, reviews and turns policy into strategies, plans and actions. The process involves the organisation identifying and managing reviews and periodical improvements to these processes.	organisation in developing and using Racial Equality policies and practices. 2. Issue written policies which incorporate a high profile public commitment to racial equality. This should be developed with an anti-racist ethos and perspective for diversity and inclusivity in its content and style, policies and strategies. 3. The organisation should practise and endorse racial diversity externally and internally in all its activities. This should be supported at Board Level or Permanent Secretary Level in the case of Government Departments. 4. Consultation, involvement and participation take place with Ethnic Minorities communities on the content of the Policy. 5. Review and revise appropriately. 6. Feedback and update outcomes to the Ethnic Minorities communities. 7. Issue guidance *for* policy makers which would include a statement of your commitment	Pre consultation with NICEM 11/10/10	2010

	to racial equality. The guidance produced should contain clear instructions and worked examples of what the commitment to racial equality means in practice and what is expected of policy makers. 8. Train staff involved in policy making, in impact assessment and policy, appraisal on racial equality. 9. Provide customised anti-racist and diversity awareness training to all staff. 10. Equality Policy Appraisal and Impact Assessment should be regarded as core skills for policy staff and should form part of annual performance appraisals. 11. Racial policy is supported by an implementation plan of on-going staff development, familiarisation and regular reviews. 12. Plan from the outset and allocate resources to ensure that the implementation and evaluation of the impact of policy initiatives are monitored with reference to their intended outcomes and to their effects		

	on different communities. 13. Ensure that Racial Equality principles are integral to the policy and planning process. This should include consultation, research, monitoring and evaluation. 14. Provide further guidance to policy makers on how to appraise policy in the light of impact assessments on what to do when proposed policies appear likely to result in adverse differential impacts on different groups in society. 15. Provide guidance on strategies for dealing with proposed policies which have adverse impacts on different groups in society. 16. Integrate Racial Equality into strategies to tackle social exclusion, such as the New Targeting Social Need initiative. 17. Address issues of Racial Inequality through policy development research. 18. Assess the needs of all Ethnic Minority communities and population profiles.		

	19. Incorporate Racial Equality objectives into the job descriptions of all levels of senior management and ensure that these are subject to annual performance appraisal and review. 20. Produce documentation for implementation of the Audit and integrate corporate and service objectives into this. 21. Draw up an action plan for implementation of the Audit. 22. Make explicit the responsibilities of all staff in relation to the policy. 23. Establish local performance indicators which clearly reflect the local diversity of community needs, aspirations and disadvantaged position. 24. Incorporate Racial Equality practices, standards and targets into quality assurance controls. 25. Incorporate Racial Equality principles in Codes, guidance documents and manuals. These should be developed where they are not currently available.		

	26. Review the content of induction packs to ensure that on and prior to appointment all staff receive suitably strong messages on the importance the organisation attaches to racial equality. 27. Train staff to promote ownership of the policy across all areas of the organisation. 28. Ensure that adequate resources are available to implement effectively Racial Equality commitments. 29. Develop at a corporate level a strategy and programme of annual Racial Equality Action Plans. These should be developed collaboratively in order to strengthen the integration of equality issues into mainstream management and practice. 30. Publish performance result in internal annual reports, as well as for reports which satisfy Section 75 of the Northern Ireland Act.		
Service Delivery and Development: Service delivery and development if a key aspect of any public authority's commitment requirements and challenges. This approach ensures that the racial diversity and distinct	1. Ensure that Impact Assessment and policy appraisal on equality are central to all new programmes and projects affecting Service	Race Equality Audit for NI. NICEM Pre consultation with NICEM 11/10/10	2004 2010

needs of our racial groups are recognised and met. An underlying commitment to meet diverse needs is integral to the success of this process.	Delivery. 2. Work with and consult with Black and Ethnic Minority groups within NI. 3. Have regular contact between Departmental Managers and Ethnic Minority communities to consult on Action Plans, Service Development and Implementation, Policy Development and Needs Assessment. 4. Produce Action Plans which detail priorities, targets, timetables and outcomes for each service area to challenge racism and racial harassment. 5. Identify the differentials between communities. 6. Produce data to support identified differential needs. 7. Develop responses to meet those needs. 8. Develop corporate and outreach strategies to target marginalised and socially excluded Black and Ethnic Minority groups to ensure equal access to all services. 9. Collect information about the services, networks and		

	resources which are available to meet the needs of Black and Ethnic Minority communities. 10. Organisations which are grant-aided by a public authority should be required to have Racial Equality policies and procedures in relation to the delivery of their services. 11. Organisations which are grant aided should provide evidence of practices which promote social inclusion of racial groups. 12. Provide anti-racism training for all staff who deliver services to Black and Ethnic Minority groups to ensure appropriateness of service and sensitivity to users. 13. Establish mechanisms for dealing with complaints of racial discrimination and/or racial harassment from service users from Ethnic Minority groups. 14. Establish mechanisms for dealing with complaints from service users from Black and Ethnic Minority groups which take into account language and communication difficulties.		

	15. Monitor services for racial equality in access, delivery and outcomes. 16. Include Racial Equality objectives in the Job Descriptions and Personal Development Plans of all staff involved in service delivery. 17. All staff should be appraised against these plans annually.		
Community Participation: Community Participation and Planning are key components to building relationships between excluded groups and organisations. This will enable authorities to combat social exclusion and deprivation that affects Ethnic Minority Communities disproportionately. This process should assist organisations to develop strategies to assist them. Consultation forms an important part of the process improving the social well being of communities. The process should involve community planning partnerships, development of long term visions focusing on outcomes and the assessment and monitoring of progress for the achievement of goals and priorities. The next stage is to feed back to your communities on your progress and intentions.	1. Establish consultation mechanisms to establish regular contact with Black and Ethnic Minority communities. 2. Promote self-help initiatives and encourage the communities to develop their own mechanisms to meet their needs. 3. Recognise the impact of institutionalised racism on service delivery to Ethnic Minority communities. 4. Aim to overcome communication, cultural and religious barriers in service delivery by regularly reviewing the profiles of your communities and ensuring adequate resources are in place.	Race Equality Audit for NI. NICEM Pre consultation with NICEM 11/10/10	2004 2010

	5. Provide information to local communities about the range of service provision made by the organisation or public authority. 6. Ensure Black and Ethnic Minority are able to input into the preparation of Action Plans and the development and delivery of services, policy development and needs assessment. 7. Develop a partnership approach between the organisation and the Ethnic Minority communities. 8. Work towards participation in decision making and in particular take account of citizenship and the views of service users. 9. Contribute to capacity building within Black and Ethnic Minority groups through support, training and grant aid. 10. Utilise the experience and skills of ethnic minority groups to conduct staff training at all levels on anti-racism and racial inequality in the organisation.		
Positive Action Initiatives: Initiatives, whether they be community based or related to employment, acknowledge the presence of	1. Tackle the under-representation of Ethnic Minority workers within	Race Equality Audit for NI. NICEM	2004

disadvantage and discrimination. Positive Action attempts to redress the imbalances Ethnic Minorities face internally as employees and externally as service users.	organisations by the maximum use of the Positive Action Provisions in the Race Relations legislation, including pre-recruitment and trainee schemes in order to redress imbalances in the workforce. 2. Introduce a range of pre-entry and post-entry initiatives to redress racial imbalances within the organisation. 3. Tackle identified unmet or new needs of Black and Ethnic Minority communities through Positive Action Programmes. 4. Target resources and grant aid to Ethnic Minority Voluntary Sector Organisations to tackle Social Exclusion as part of a capacity building programme. 5. Organisations should develop an on-going research programme to address issues of inequality, such as the changing nature and complexity of disadvantage, unequal access and unequal impact. 6. Require all contractors and those to whom functions are out-sourced to follow effective racial practice in employment	Pre consultation with NICEM 11/10/10	2010

	and service delivery. 7. Develop monitoring and compliance systems for the purchase and contracting of services and works. 8. Encourage contractors who breach equality and diversity policies to improve their performance. A range of lawful sanctions can be applied where appropriate up to and including the termination of the contract. 9. Be aware of the range of sanctions you can apply and practise diligence at all times. 10. Regularly review and update your supplier list and publicise its existence especially in the Ethnic Minority Communities. 11. Develop mechanics to address under-representation not only in terms of access but also retention and progression. 12. Adopt a proactive and creative approach to communities in relation to strategies to combat disadvantage.		
Workplace Developments: Organisations should deploy **all** their human resources in a way that supports Racial Equality policies and plans. Organisations can then assess their	1. Take positive steps to increase the numbers of staff from under-represented Ethnic Minority Groups at all levels of	Race Equality Audit for NI. NICEM Pre consultation with NICEM	2004 2010

policies for recruitment, training, review and promotion of all staff.	the organisation. 2. Ensure all recruitment and selection procedures are bias free, equality-proofed and do not discriminate unfairly or unlawfully. 3. Target publicity in appropriate media for vacancies and opportunities in order to reach the widest possible pool of candidates. 4. Ensure all recruiters and selectors are trained to carry out the process in an equitable manner and are given refresher training. 5. Establish a Register of Recruiters and Selectors. 6. Ensure recruiters and selectors are representative of the Ethnic Minority Communities you serve. 7. Build in criteria to all job descriptions to assess understanding and commitment to racial diversity issues. 8. Test for understanding of racial diversity issues in assessment and selections process. 9. Establish appropriate Racial	11/10/10	

	Equality objectives and targets for all grades and professions in your organisation. 10. Analyse racial background data for applications and appointments for use in the review of progress on Racial Equality targets. 11. Manage and support Ethnic Minority staff through a range of mechanisms: • Appropriate Cultural Support • Ethnic Minority Worker Support Groups • Build capacity of Ethnic Minority Support Groups to sustain and develop their role and profile • Develop a mentoring scheme for Black and Ethnic Minority staff • Develop consultation mechanisms to elicit feedback and ideas from Ethnic Minority staff • Develop interventions which combat disadvantage and provide strategies for progression for all levels of Ethnic Minority staff		

	• Develop innovative and appropriate interventions to allow for career progressions of the Ethnic Minority workforce • Develop innovative positive action training for Ethnic Minority staff. 12. Ensure that staff induction programmes and manuals for new staff include information about racial equality and the organisation's anti-racism commitment. 13. Develop a Comprehensive Training Plan that delivers differentiated racial awareness training to staff at all levels within your organisation. 14. Audit all existing training development interventions for bias in content, style and delivery. 15. Incorporate a racial equality dimension in all training and staff development programmes. 16. Develop a multi-racial working environment by examining the following procedures to ensure that they are fair and effective:		

	• Grievance procedures • Disciplinary procedures • Racial harassment and policies and procedures • Staff appraisals • Religious and cultural needs • Health and safety policies. 17. Launch the Racial Harassment Policy and publicise it to all Stakeholders. 18. Train and develop harassment contacts that reflect the racial diversity in your organisation. 19. Develop a framework for Racial Harassment Contacts. 20. Equip managers to produce, implement and monitor action plans. 21. Train managers on the detailed implementation of Action Plans and racial equality programmes. 22. Monitor data on Ethnic Minority staff retention and turnover rates. 23. Monitor grievance and disciplinary procedures involving staff from Ethnic		

	Minority backgrounds. 24. Build Racial Equality Objectives into job descriptions at manager level and above. These should be subject to annual performance appraisals. 25. Monitor all aspects of employment and identify areas for follow up action.		
Marketing and Communications: An essential element in any organisation's activities is its external and internal communications. Demonstrating racial equality in our communications in content, style and approach is essential to successful interactions. Internal and external lines of communication and accountability should be bias free, racially sensitive and inclusive.	1. Review the accessibility of all major publications and publish in all appropriate formats. 2. Review the accessibility of the formats your communications are produced in. 3. Reflect diversity in all public communications about services in order to counter and avoid stereotypical or prejudiced attitudes. 4. Make staff aware of the Racial Equality policy through a range of internal media (internet briefings / updates). 5. Promote greater involvement of all sections of the community at organisation events. 6. Work to ensure that your organisation is seen as a	Race Equality Audit for NI. NICEM Pre consultation with NICEM 11/10/10	2004 2010

	standard setter for equality in its communications. 7. All marketing staff should develop marketing strategies that are inclusive of race. 8. 8 Assess / audit all literature for stereotypical representations or misrepresentations of any groups. 9. Use minority media, in its widest sense, in placing advertisements and news coverage. 10. Update lists and resources on minority media periodically. 11. Make full use of appropriate services, e.g., translation, interpreting and advocacy. 12. Involve appropriate staff from disadvantaged groups at high profile public events in a meaningful way. 13. Ensure community events that are organised are of direct relevance to a variety of groups, including those who are disadvantaged. 14. Senior staff should act as 'ambassadors' to promote Racial Equality objectives, and		

	share good practice at external events, for example, Conferences, Media Interviews, Public Statements etc. 15. The range of community events sponsored or funded by the authority should reflect the commitments and values of the racial policy. 16. Use recall surveys to assess your performance in promoting awareness of Racial Equality Policy and Activities. 17. Feed in recall surveys to media and communications policy effectiveness review, and policy development.		
Obesity – Members advised that foreign nationals coming here from example Portugal were not eating healthy food as they did back home and many of them had put on a considerable amount of weight here (average 2 stone) due to change in diet. **Health Information for Travellers** should not be in written form and should be culturally sensitive as not all Traveller families are the same. Service providers need to be aware of **Group cultural differences and cultural needs.** More **outreach work** was needed and **relationships needed to build with men**	**More translated health promotion for BME communities around healthy living.** **Targeted health promotion** **Health Outreach Programmes**	Pre consultation with local BME representatives in the Southern Trust Area 14/10/10	2010

around men's health. Receptionists act as gatekeeper to services **and training was needed on staff attitudes.** **There appears to be an unequal footing between the Interpreter and the Practitioner** **Promote participation** by training community and voluntary groups on how they can influence the Trust decision making process. **Volunteers and health mentors needed from the Travelling community**. **Employment –** difficulty in getting references, need for interview preparation skills. Sample questions and answers. Where are posts advertised? Need for Job Fairs. The focus on electronic applications has created huge barriers. Internal trawls do not help in employing migrant workers. **Benefits trap** discourages Travellers to apply for posts. Front line staff should reflect the local community. Need for Bi Lingual Speech Therapists and Psychologists, Counsellors. As these services do not work through Interpreters. Need to concentrate on new communities coming in e.g. increase in Latvian community. Also rise in Roma community – poverty – no recourse to public funds. Health is not a concern for Migrant Workers	**Treat people with respect**. **Skill up the community sector.** **Employment –** specifically employ reflecting the local community. **Help on filling out application forms** **Posts need to be advertised through the local network of community and voluntary organisations and not the press** **Realistically look at Interpreter training and upskill interpreters.**		

until they become ill. Illegal immigrants not entitled to register with GP. They have to pay for GP consultation. It used to be you just had to provide an address now need to bring passport. Recruitment companies are still recruiting in other countries even though there is a recession here. **Older BME communities** have multiple disadvantages. They come here to look after grandchildren, no English language, socially isolated. **This is a major concern – they are not integrated into anything outside the home** **Still births** – no Islamic services – very Christian. **Need for minority chaplains** Trust needs to consider - **How do you get your information out to MW's?** Importance of registering with GP and completing census forms so that Trust are able to reflect numbers in service planning.	**Racial profiling?** **Need to engage with older BME communities – look at research on Polish community in Australia** **Patients should be asked what they need** **Need to go through local employers induction and BME support groups** **Help with completing census**		

HSC Audit of inequalities: Emerging Themes: Sexual Orientation

The table below attempts to summarise issues highlighted in some of the more recent literature relating to sexual orientation, published since 2005. It is not the result of any systematic literature searches nor does it critically review any of the sources.

What are the Equality/ Inequality Issues?	Potential solutions where these are offered in the literature Policy/Practice Issues?	Source of Evidence	Date
1. Employment			
Atmosphere and culture of discrimination, homophobia and heterosexism (language, jokes, comments, graffiti).	• Zero tolerance policy regarding homophobic bullying and harassment; clear message to all staff on what constitutes inappropriate behaviour and to managers about their responsibilities. • Use neutral language in communication • Training (building capacity and confidence to challenge inappropriate behaviour). • Conduct research on perceived conflicting freedoms.	Hansson, Ulf, Molly Hurley Depret and Barry Fitzpatrick: Equality Mainstreaming. Policy and Practice for LGB People. Institute for Conflict Research Hunt, Ruth; Katherine Cowan and Brent Chamberlain: Being the gay one: Experiences of lesbian, gay and bisexual people working in the health and social care sector. Stonewall British Medical Association (BMA): Sexual orientation in the workplace NHS Scotland: Fair for all – The Wider Challenge. Good LGBT Practice in the NHS. Stonewall BMA: A celebration of lesbian, gay, bisexual and transgender doctors' contribution to the NHS: a collection of members' experiences. London	2007 2007 2005 2006 2009

Lack of confidence in reporting and disciplinary procedures.	• Confidential reporting process to protect individuals not out. • Create support systems (through unions, associations, staff networks). • Communicate rights of LGB staff with payslips or information leaflets.	Hunt et al BMA Hansson et al	2007 2005 2007
Lack of visibility of LGB people in the health and social care workplace.	• NHS to acknowledge its LGB staff, create a safe environment (peer support, mentor system, highlighting successful careers, role models, display of positive posters, information leaflets targeted at LGB staff and identified contact person for LGB issues). • Create support systems (through unions, associations, staff networks). • Monitoring – collect data on LGB employees and their experiences in tandem with creating safe space to disclose. • Work-life balance policies need to explicitly state that they apply to LGB people also; harassment and bullying policies to be specific about homophobia.	Hunt et al. BMA NHS Scotland BMA Discussion with Rainbow Discussion with Strabane and Lifford LGBT Group	2007 2005 2006 2009
Negative impact on delivery of services		Hunt et al BMA	2007 2005
2. Services			
Reluctance to disclose sexual orientation to GPs and delays in seeking care due to fear of attitudes and discrimination.	• Require GP practices and hospitals to develop and prominently display equality policies explicitly including sexual orientation. • Guidelines for GPs and hospitals about confidentiality and patient notes. • Display positive images of gay couples in appropriate settings. • Booklet for GPs how to sensitively and	Hansson et al NHS Scotland BMA Discussion with Rainbow	2007 2006 2005

	effectively communicate with LGB people.		
Specific needs for mental health services: (higher incidents of eating disorders and self-harm, higher alcohol consumption, drug use, smoking – often in response to experience of homophobia).	• Comprehensive health strategy for LGB people, taking account of multiple identities.	Hunt, Ruth and Adam Minsky: Reducing health inequalities for leasbian, gay and bisexual people: evidence of health care needs. Stonewall Discussion with Strabane and Lifford LGBT Group	2006
Some preventative public health messages only target heterosexuals.		Hunt et al	2006
Lower participation in cancer screening.	• Comprehensive health strategy for LGB people, taking account of multiple identities.	Hunt et al Discussion with Strabane and Lifford LGBT Group	2006
General lack of recognition of domestic violence amongst same-sex couples.		Hunt et al	2006
Negative experiences of health services	• Raise awareness of staff about need for neutral language ; booklet for GPs how to sensitively and effectively communicate with LGB people; challenge inappropriate language. • Training (building capacity and confidence to challenge inappropriate behaviour), developed in collaboration with LGB groups, possibly focus on team leaders first. • Require GP practices and hospitals to develop and prominently display equality policies explicitly including sexual orientation. • Guidelines for GPs and hospitals about confidentiality and patient notes. • Display positive images of gay couples in	NHS Scotland BMA Hansson et al Discussion with Strabane and Lifford LGBT group	2006 2005 2007

	appropriate settings. • Build on existing partnerships to engage closely with local LGB groups to identify areas for change and support for raising complaints. • Service providers to find out about local support groups and services for signposting to LGB service users. • Start monitoring in small service areas and expand to all services over time; publish monitoring results and demonstrate impact of monitoring on service improvement. • Consider introducing champion (with specialist knowledge).		
Reluctance to raise a complaint.	• Address LGB issues in induction training for newly appointed doctors. • Mandatory training for staff. • Participation in LGB awareness raising to be part of Continuing Professional Development.	Hansson et al. NHS Scotland Discussion with Strabane and Lifford LGBT group	2007 2006
Concern that GPs are not covered by Section 75.		BMA Hunt et al	2005 2006
3. Cross cutting issues with other Section 75 Categories			
Age			
Young People • Homophobic bullying at school, access to support networks, lack of positive role models. • Even less likely to be out to GP for fear of disclosure to family; might be more likely to attend STI clinic.		Hunt et al Hansson, et al	2006 2007
Older People	• Need for affirming environments to ensure older	Hunt et al	2006

• Concerns about provision of social care (more likely to live alone and without children; concerns about access to appropriate care). • Society and health messages assume LGB people are young and active.	LGB people are comfortable to disclose their sexual orientation. • Service providers need to recognise families of choice and involve in consultations about care. • Direct Payments.	Hansson, et al Musingarimi, Primrose: Older Gay, Lesbian and Bisexual People in the UK. A Policy Brief. London: ICL-UK	2007 2008
• Some cohorts experienced severe oppression by institutions hence aversion to accessing services. • Greater fear of safety of home being invaded if care provider is homophobic. • In comparison to younger LGB people less experience of LGB community. • Older LGB people may feel that organisations providing support to LGB people are less in tune with their particular needs.		Musingarimi, Primrose: Health issues affecting older gay, lesbian and bisexual people in the UK. A Policy Brief. London: ICL-UK Musingarimi, Primrose: Social care issues affecting older gay, lesbian and bisexual people in the UK. A Policy Brief. London: ICL-UK Heaphy, Brian, Andrew Yip and Debbie Thompson: Lesbain, Gay and Bisexual Lives over 50. Nottingham Trent University, Dept of Social Sciences	2008 2008 2003
Gender			
Lesbian Women • Even less visible than gay males. • Less research on lesbian women than gay men. • Debate around higher risk of breast cancer (due to smoking and poor diet; less	• Research on health needs of lesbian women. • Include information specifically for lesbian service users to address misconceptions about 'immunity' in follow up letters. • Develop health strategy for LGB people (e.g. Australia, state of Victoria). • Make lesbian women and their families visible in health promotion campaigns.	BMA Hunt et al. Query, Marie: Invisible Women. A review of the impact of discrimination and social exclusion on lesbian and bisexual women's	2005 2006 2007

likely to have children). • Specific health issues relating to fertility, pregnancy, sexual health, mental health; weight issues, eating disorders, relationships, smoking/drugs/alcohol abuse. • Generally unhappy with level of service received. • Lack of dedicated counselling service for lesbian and bisexual women. • Access services less frequently than other women. • 2-3 times more likely to attempt suicide; higher levels of self-harm; 1 in 2 chance of mental illness at age of 16 in NI. • Service providers are often misinformed and underinformed about lesbian health issues.	• Incorporate specific needs into undergrad and postgrad training. • Further research on specific groups amongst lesbian and bisexual women. • Establish dedicated resource centre.	health in Northern Ireland. LASI.	
Bisexual Women • Compared with women who have sex exclusively with men: more likely to have higher numbers of male partners and higher levels of unsafe sex; to have		Musingarimi	2008

induced abortions; to have diagnoses of sexually transmitted infection.			
Gay Men • Concerns about issues relating to mental health, sexual behaviour, safety, weight issues, eating disorders, lack of role models, and relationships, smoking/drug/alcohol abuse. • Gay men at greatest risk of HIV infection; higher risk from sexually transmitted diseases. • Sometimes at higher risk (partly because they don't respond to public health messages, partly because of lifestyle and reaction to social issues). • Living with diagnosed HIV more common among Black men rather than other ethnic groups, men with lower levels of former education, men who have sex with men only rather than bisexual men, men who have more sexual male partners.		Hunt et al Weatherburn, Peter et al.: Multiple chances. Findings from the UK Gay Men's Sex Survey 2006. Sigma Research	2006 2008
Disability			
• People with disabilities	Need for clear policies and guidance and training	Hunt et al	2006

often considered to be asexual. • Many disabled LGB people have not received relevant sex education. • Lack of appropriate information about sexual health and fertility issues. • May encounter difficulties in accessing mental health services. • Difficulties in meeting other disabled LGB people. • Lack of acceptance in mainstream LGB scene.	for social care staff to offer appropriate support.	Department of Health: Disabled lesbian, gay and bisexual people. Briefing 13	2007
Ethnicity			
• Compared with white gay men, African-Caribbean men twice as likely to be living with diagnosed HIV, South Asian men less likely. • BME domestic violence service mainly targeted at meeting needs of heterosexual women. • BME LGB people even more likely to be victim of homophobic violence than white LGB people. • BME LGB people less likely than white LGB people to have considered suicide, possibly due to cultural and religious taboos.		Department of Health: Lesbian, gay and bisexual people from black and minority ethnic communities. Briefing 12 Discussion with Rainbow	2007

• LGB groups feel less confident themselves in meeting needs of BME (language barriers).			
Rurality			
• People in rural areas even less likely to be out to GP for fear of disclosure to community. • Lack of research.		Hansson et al Discussion with Strabane and Lifford LGBT group	2007
4. Lack of information			

Employment
• Needs and experiences of
  • LGB people in non-medical HSC and public safety professions (nurses, AHP, social care workers / social workers);
  • HSC or Public Safety employees in NI;
bisexual people.			

Services
• Health needs/experiences of LGB people
  • w/dependents;
  • married/widowed/ divorced;
  • older;
  • political opinion;
  • religion;
  • disability;
  • ethnicity;
  • rurality.
Generally less literature on social care needs/ experiences of LGB people.			

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