Health and Social Care

Audit of Inequalities

October 2022

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Introduction

Section 75 (S75) of the Northern Ireland Act 1998 requires all of the 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 dependents 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. The Equality Commission Northern Ireland (ECNI) revised guidance "Section 75 of the Northern Ireland Act 1998 – A Guide for Public Authorities" emphasised the need for public authorities to carry out an audit of inequalities and produce an associated action plan. The purpose of an Audit of Inequalities is to provide a strategic picture of inequalities relevant to the role and functions of an organisation.

"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." [1]

[1] Equality Commission for Northern Ireland (ECNI) (2010). Section 75 of the Northern Ireland Act 1998 - A Guide for Public Authorities, April 2010 (The Guide)

Substantial progress has been made since the Trusts published their first plans on 1 May 2014 and their second plans in April 2018 - details of what we have done so far can be found in Trusts' respective Annual Progress Reports, which are available online, and in alternative formats on request.

There are six Health and Social Care (HSC) Trusts in Northern Ireland. Five of these provide integrated health and social care services across Northern Ireland. These are as follows.

- Belfast HSC Trust
- Northern HSC Trust
- South Eastern HSC Trust
- Southern HSC Trust
- Western HSC Trust

The Northern Ireland Ambulance Service is the sixth Trust and is responsible for providing emergency, urgent and primary care services throughout the whole of Northern Ireland and safely transporting patients.

The five HSC Trusts and the Northern Ireland Ambulance Service Trust have developed the regional Audit of Inequalities collaboratively.

The links to each Trust website are below:
www.belfasttrust.hscni.net/
www.nias.hscni.net/
www.northerntrust.hscni.net/
www.setrust.hscni.net/
www.southerntrust.hscni.net/
www.westerntrust.hscni.net/

The Equality Commission's guide, "Section 75 of the Northern Ireland Act 1998 - A Guide for Public Authorities" states'

'In order to effectively demonstrate that a public authority has paid due regard to the need to promote equality of opportunity and regard to the desirability of promoting good relations through the implementation of its equality scheme, a public authority should develop action measures/action plans to promote equality of opportunity and good relations'.[2]

The guide also recommends that an Audit of Inequalities should be completed to identify inequalities, which exist for service users, and those affected by a Trusts' policies and Equality Action Plans should address the inequalities identified.

This report details how the Trusts have updated their audit of inequalities. The results of this audit has informed the equality action plan for the five years ahead.

This is a rolling audit and it will be updated periodically as further relevant data becomes available to inform the Trusts. The Trusts welcome feedback from all stakeholders about how the audit could be further expanded or improved.

[2] ECNI (2010). Section 75 of the Northern Ireland Act 1998 – A Guide for Public Authorities, April 2010

Audit of inequalities - methodology

HSC Trusts worked collaboratively to ensure consistency of approach and equity across the region. A wide range of research and direct stakeholder engagement informs this Audit of Inequalities. We have also considered the health and social care inequalities exacerbated by the impact of the coronavirus pandemic. The key research documents that informed this audit are available in Appendix 1.

In addition to the desktop review, the HSC Trusts engaged with a number of stakeholders to reflect on progress, learn from diverse stakeholder perspectives and share ideas to inform the plans.

It is important to note that many of the inequalities identified through this audit extend beyond the remit of the Health and Social Care alone and require a wider partnership approach. Where a wider approach is required Trusts are committed to ongoing collaborative working with other public sector organisations and the voluntary and community sector through, for example, active working in partnership groups with local councils to create community planning health and wellbeing goals specific to each council area.

Trusts address many health inequalities through the day-to-day provision of specific functions covered by the duty to deliver health and social care services to the public in Northern Ireland. As an example, higher prevalence of mental health is directly addressed regionally through the implementation of the Mental Health Strategy and delivery of mental health services across the Trusts. From the outset, it is important to acknowledge that the equality action plan produced from this audit will not be able to tackle all of these systemic inequalities but will focus on those inequalities in health and social care experienced by those protected in law by the equality and good relations duties of Section 75 of the Northern Ireland Act 1998.

The research and stakeholder engagement has identified the following common themes across Section 75 categories.

1. Improved data and monitoring
2. Barriers to accessing health and social care
3. Supporting our staff
4. Support for carers
5. Partnership working

The identified themes include those that require a wider sectoral approach and those that promote equality of opportunity and good relations for the nine equality categories outside this day-to-day provision. The plans describe the desired outcomes along with related timescales.

Summary of key findings

The following is a summary of the key findings across the S75 equality groups from the research examined and engagement with stakeholders. Also included is a section covering general comments made at the listening events not specific to a particular S75 grouping.

Age

What we found:

- The population of Northern Ireland on census day, 21 March 2021, was 1,903,100. The population comprised 967,000 females and 936,200 males, which means that for every 100 women there were 97 men. On census day, there were 365,200 children (aged 0 to 14) or 19% of the population. Those aged 65 and over represented 17% (326,500) of the population. The remaining 64% of the population, or 1,211,400 people, were aged between 15 and 64 years.[3]
- Since 2011, the population has increased by 92,200 or 5%; and the population aged 65 and over has seen the largest increase of 62,800 or 24%.
- General trends in the 2021 Census shows that the number of children aged 0 to 14 years are decreasing whilst the proportion of the population aged 65 and over has increased. It is expected that within the next ten years, there will be more people aged 65 and over than children aged 0 to 14 years.[4]
- 20% of all employees and 32% of employees aged 55 and over have experienced unwanted behaviour on the grounds of age.[5]

[3] NISRA (2021). Census 2021 Available at: https://www.nisra.gov.uk/statistics/census/2021-census. (Accessed: 28 November 2022)
[4] NISRA (2021). Census 2021 Available at: https://www.nisra.gov.uk/statistics/census/2021-census. (Accessed: 28 November 2022)

- Need for provision of age appropriate mental health support, better management of transition from child to adult services, and support for young transgender people.[6]
- Although the number of older people who are digitally connected continues to rise, there are still around 5 million people over the age of 55 who are not online. While factors such as income and levels of education play a part, age is still the biggest indicator of who is digitally excluded.[7]

What you told us:

- Times of appointments for older people can impact equality of access to services.
- Need for access to appointments out of hours
- Lack of accessible transport - community transport is a vital link for so many people. Although community transport is good, it does not cover out of hours.
- Rurality impacts on equal access to services due to lack of accessible transport, times of appointments and rural / community transport availability.
- Poverty can impact on attendance at appointments due to the affordability of travel and parking costs.
- A widening of the digital divide impacting older people, the issue of digital inequalities

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[5] ECNI (2020) A Welcoming and Inclusive Workplace Employee Information Gathering Exercise, Mar 2020. Available at: https://www.equalityni.org/ECNI/media/ECNI/Publications/Delivering%20Equality/WorkplaceEmployeeSurvey-Part1Intro.pdf (Accessed: 28 November 2022)
[6] ECNI (2017) Age Equality Policy Priorities and Recommendations, Dec 2017. Available at: ECNI - Delivering Age Equality in Northern Ireland (equalityni.org) (Accessed: 28 November 2022)
[7] Centre for Ageing Better (2022). Digital Inclusion. Available at: Digital inclusion | Centre for Ageing Better (ageing-better.org.uk) (Accessed: 28 November 2022)

- Increase in mental health conditions among young people and difficulties accessing GPs.
- Neurodiversity services should be available for young people.

Men and women generally

What we found:

- Early 2021 Census data shows that the population of Northern Ireland on census day 2021 was 1,903,100 people. There were 967,000 females and 936,200 males, representing 51% and 49% of the population respectively.[8]
- Variances in life expectancy throughout Northern Ireland remain.[9] Although females In Northern Ireland are more likely to self-harm and attempt suicide, men are three times more likely to die by suicide.[10]
- In the UK, the percentage of nurses who are male has stayed at about 11.5% for the last decade. Universities in Northern Ireland have acknowledged that men are under-represented in their universities current nursing programmes.[11]
- Attracting, supporting and retaining a diverse NHS workforce. Low participation among men in nursing and midwifery in particular[12]

[8] NISRA (2021) Census (2021). Available at: https://www.nisra.gov.uk/statistics/census/2021-census (Accessed: 28 November 2022)
[9] Department of Health (2022). Health Inequalities Annual Report 2022. Available at https://www.health-ni.gov.uk/sites/default/files/publications/health/hscims-report-2022.pdf (Accessed: 28 November 2022)
[10] Research Matters (2019). Suicide Statistics and strategy in Northern Ireland. Available at: Suicide statistics and strategy in Northern Ireland, 2019: Update - Research Matters (assemblyresearchmatters.org) (Accessed: 28 November 2022)
[11] Androus, A.B. (2022). Sexism in Nursing is a Problem but not like you think. Available at: https://www.registerednursing.org/articles/sexism-nursing-problem-not-like-you-think/ (Accessed: 28 November 2022)

- Women are more likely than men to be forced out of the labour market by unpaid, domestic work or caring responsibilities; 69% of carers in Northern Ireland are women. Women have a 70% chance of providing care in their adult life; compared to 60% for men. By the time they are 46, half of all women have been a carer (11 years before men). This remains a key issue for Trusts themselves given the percentage of female employees.[13]
- Women currently make up half the workforce in Northern Ireland and at some stage during their working lives they may have to work through the menopause. Whilst statutory equality law does not expressly provide protection, those who suffer discrimination in employment directly or indirectly may be able to seek legal remedies if alleging they have suffered unlawful discrimination or harassment on the grounds of sex, disability or age [14]
- 26.9% of complaints of discrimination to ECNI during 2020/21 were sex related [15]
- There is a higher proportion of women working flexible working patterns than men. Work quality data also show lower proportions of women than men earning above the Real Living Wage and agreeing that their job offers opportunities for career progression [16]
- Separate or single-sex service providers are those who provide a service where some element or all of the service is available only to one sex, or separately to each sex, or differently to people of each sex. These

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[12] Hemmings, N.et al (2021). Attracting, supporting and retaining a diverse NHS workforce. Available at: https://www.nuffieldtrust.org.uk/files/2022-10/1636121852-nhs-workforce-diversity-web.pdf (Accessed: 28 November 2022)
[13] Carers UK (2019). Will I care? The likelihood of being a carer in adult life. Available at: https://www.carersuk.org/images/News__campaigns/CarersRightsDay_Nov19_FINAL.pdf (Accessed: 28 November 2022).
[14] ECNI et al. (2020). Promoting Equality in Employment for Women Affected by Menopause Guidance for Employers, Trade Union Representatives and Employees. Available at: https://www.equalityni.org/ECNI/media/ECNI/Publications/Employers%20and%20Service%20Providers/MenopauseInWorkplace.pdf (Accessed: 28 November 2022)
[15] ECNI (2021). Annual Report and Accounts 2020 – 2021. Available at: https://www.equalityni.org/ECNI/media/ECNI/Publications/Corporate/Annual%20Reports/AnnualReport2020-21.pdf (Accessed:28 November 2022)
[16] NISRA (2022). Women in Northern Ireland 2020/21. Available at: https://www.nisra.gov.uk/system/files/statistics/women-in-Northern-Ireland-2020-2021.pdf (Accessed: 28 November 2022)

could include but are not limited to separate or single-sex toilets, domestic violence refuges, separate or single-sex changing rooms and hospital wards[17]

- Very few respondents to NHS Staff Surveys self-identify as lesbian, gay bisexual or transgender meaning data on these groups can be less reliable[18]
- In Northern Ireland during 2020/21 males represented 31% of all domestic abuse victims[19]

What you told us:

- In terms of recent population profiles, there is a lot of evidence that men are reluctant to access services
- Services need to take into consideration and prioritise menopause and period poverty.
- There needs to be a regional position or approach regarding people who are transgender or non-binary for example, accommodation, and best practice guidance on inclusion.
- There needs to be access to transgender support service in the region.

[17] Equality and Human Rights Commission (2022). Separate and single-sex service providers: a guide on the Equality Act sex and gender reassignment provisions. Available at: Separate and single-sex service providers: a guide on the Equality Act sex and gender reassignment provisions | Equality and Human Rights Commission (equalityhumanrights.com) (Accessed: 28 November 2022)
[18] Hemmings, N. et al. (2021). Attracting, supporting and retaining a diverse NHS workforce. Available at: Research report (nuffieldtrust.org.uk) (Accessed: 28 November 2022)
[19] PSNI (2021). Trends in Domestic Abuse Incidents and Crimes Recorded by the Police in Northern Ireland 2004/05 to 2020/21. Available at: Trends in Domestic Abuse Incidents and Crimes Recorded by the Police in Northern Ireland 2004/05 to 2020/21 (psni.police.uk) (Accessed: 28 November 2022)

Disability

What we found:

- The 2011 census for NI reported that 21% of resident population here had a long-term health problem or disability that limited their day-to-day activities.[20]
- 'Disability discrimination' was the most common reason a person contacted the Equality Commission for advice in 2020/21; people with disabilities report negative attitudes towards them.[21] 88% of d/Deaf and disabled people feel that there are negative attitudes and discrimination towards them in Northern Ireland.[22] In addition, 76% of d/Deaf and disabled people do not have access to enough support to live independently and there is a lack of accessible toilets and play facilities.[23]
- A lack of training in some areas of disability (e.g. learning disability) has a profound impact on health outcomes. Mencap cites that a lack of training for health professionals could be contributing to 1,200 avoidable deaths of people with a learning disability happening every year; 38% of people with a learning disability die from avoidable causes, compared with 9% of the general population.[24]
- Northern Ireland has the highest prevalence of mental health problems in the UK, with a 25% higher overall prevalence of mental health problems than England.[25] There were high rates of mental health issues reported amongst disabled people. COVID-19 has also significantly impacted mental health in Northern Ireland. Lockdown, shielding and social distancing, the closure of schools, working from home,

[20] NISRA (2011) Census 2011. Available at: www.nisra.gov.uk/statistics/census/2011-census (Accessed: 28 November 2022)
[21] ECNI (2021) Equality Commission for Northern Ireland Annual Review 2020/21. Available at: EQUALITY COMMISSION (equalityni.org) (Accessed: 28 November 2022)
[22] Disability Action (2021) Disability Research for Independent Living and Learning. Available at: Research | Disability Action Northern Ireland (Accessed: 28 November 2022)
[23] Disability Action (2022) Disability Action Manifesto.
[24] Mencap (2018) Treat me well campaign. Available at: Concerns over lack of clinical training causing avoidable learning disability deaths | Mencap (Accessed: 28 November 2022)
[25] Department of Health (2021) Mental Health Strategy 2021-2031.

increased deaths and a reduction in face-to-face services have all had an impact on the emotional wellbeing of many, including those with existing mental health conditions.[26]

- Health and social care information should be available in alternative formats for service users with disabilities who require it.[27]
- Health care appointments should be provided in a way that meets an individual's access needs. Choices should be provided such as face-to-face, virtual appointments or with the appropriate communication support in place.[28]
- Communication difficulties for deaf and hard of hearing people posed by service providers and workers wearing face masks [29]
- People with disabilities were less likely to feel that their workplace culture was welcoming and inclusive across most statements. For example, people with disabilities, when compared to all respondents, were less likely to agree with statements, such as "My workplace seeks to support employees with disabilities" (51% v 60%) and people with disabilities (34%) were more likely to have experienced unwanted behaviour during the past 12 months, when compared to all the employees who responded to this survey (21%). [30]

What you told us:

- Communication and information must be accessible to access services/appointments.

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[26] Office for Statistics regulation (2021). Review of mental health statistics in Northern Ireland 2021 Available at: Review of mental health statistics in Northern Ireland – Office for Statistics Regulation (statisticsauthority.gov.uk) (Accessed: 28 November 2022)
[27] RNIB (2022.) RNIB's Manifesto for the Northern Ireland Assembly Elections 2022. Available at: RNIB publishes manifesto for the Northern Ireland Assembly Elections 2022 | RNIB (Accessed: 28 November 2022)
[28] RNID (2022). RNID Manifesto 2022. Available at: Our manifesto for the Northern Ireland Assembly election - RNID (Accessed:28 November 2022)
[29] ECNI (2020). Face masks – overcoming the barriers they pose to communication. Available at: Face masks – overcoming the barriers they pose to communication (equalityni.org) (Accessed: 28 November 2022)
[30] ECNI (2020). A Welcoming and Inclusive Workplace.

- People with sensory disability may miss appointments if communication is not accessible. s creates a barrier to accessing services and may lead to the appointment being missed. Recording details such as asking people what way they would like to be communicated with / the format, the time and format of the appointment may help with this. This system could also help with service navigation. Involvement of service users could help with the design of ENCOMPASS.
- Staff recognising if someone is hard of hearing or deaf is important, particularly when they turn up in crises. For example, there is a remote interpreting service but not everyone is fully aware of this.
- Another barrier for the deaf community is when there is no sign language interpreter. More needs to be done to promote interpreting services for people who are Deaf/or who use sign language to communicate.
- There is a need for dementia diagnosis services and associated training.
- For those who have not had an official diagnosis - access to information is vitally important.
- The JAM (Just a Minute) card which is run by the NOW group has been developed by service users. This is useful for so many conditions such as a brain injury, learning disability or a mental health condition where a service user may have a communication difficulty.
- Consider the use of flexible working to enable staff with mental health conditions to attend appointments.
- The mental health of young people and school-age children was raised and issues arising from use of social media, alcohol or drugs. Ensure parents can access appropriate support and guidance.
- The subject of neurodiversity was highlighted and the need to raise more awareness both in the workplace and outside possibly by communications training. When thinking about protected groups,

miscommunication or poor communication can be a problem; not getting the right information to people at the right time.

- Training in communicating with patients with a learning disability or other disabilities is important. There is a need to train HSC staff at different levels and have at least one or two staff members trained in each department to ensure patients are cared for responsively.

- The approach and communication when engaging with someone who is living with dementia is very different from the communication with someone who has a learning disability or someone else who is neurotypical or someone who is neurodiverse. Having communications training to explore these in detail would go a long way to helping.

- Equality and diversity training is mostly delivered in an e-learning format; suggested more interactive segments to discuss and get a feel of real-life scenarios or presenting on different scenarios to share ideas.

- Change how we approach disability and relationships. There needs to be education and training around supporting (not denying) relationships.

- Expand lived experience involvement in equality training and support for staff. Training involving experts by experience bringing real-life scenarios is a brilliant way to meet the educational need of staff.

- Dual diagnosis for both addictions and mental health, can only access mental health services if use of substance use has dropped to a specific level. There are patients presenting in acute hospitals with substance use issues. There needs to be investment in support in the community following discharge.

- Employability and access to work including application forms and interviews - consider reasonable adjustments required and the use of a service user/carer as a panel member.

- Consider adult apprenticeships leading to potential employment within the health service for adults with a disability

Dependents

What we found:

- Prior to the COVID pandemic there were about 220,000 unpaid carers in Northern Ireland, with over a quarter providing more than 50 hours of care per week. Many do not get the care and support they need to enable them to live, full and meaningful lives alongside their caring role. The number of carers in Northern Ireland is expected to grow to at least 400,000 carers by 2037.[31]
- Despite carers' rights to assessments only 26% of Northern Irish carers reported having an assessment in the last 12 months of those, 24% waited more than 6 months for their assessment. Of those who hadn't requested a carer's assessment, 46% stated that this was because they didn't know what it was and 14% stated it was because they didn't think it would be beneficial. 12% of carers said their assessment had been postponed or they were still waiting.[32]
- 34% of carers rated their mental health as bad or very bad. Looking at wider indicators of wellbeing, 36% of carers reported that they are often or always lonely, otherwise known as being 'chronically lonely'. Carers also rated their overall satisfaction with life at an average of 5 out of 10 and their level of anxiety at

[31] Carers NI (2022). A commitment to carers. A manifesto to support unpaid carers in Northern Ireland (2022-2027)
[32] Carers UK (2021). State of Caring 2021 in Northern Ireland

6 out of 10. Almost three quarters of carers (74%) feel isolated or lonely because of their caring role. The need for shielding and social distancing during the pandemic has made this even more acute. Prolonged isolation over the course of the pandemic may have serious health implications for carers. Without access to appropriate emotional support, carers will be at greater risk of experiencing chronic stress, anxiety, or depression.[33]

- When asked about barriers to accessing support, carers said they did not know what services were available in their area, with 44% of carers reporting this as a barrier.[34]
- Over 60% of carers have not had any breaks from caring during the pandemic. 6 in 10 carers are worried that services they rely on will not return to pre-pandemic levels.[35]

What you told us:

- Family carers, many of whom were older people themselves, stepped in or increased the level of caring they provided for relatives, some while continuing their own paid work or other responsibilities. COVID-19 led to a significant reduction in the level of support provided to carers, even though they were providing more care than ever before. This has had a significant impact on their health and wellbeing with Carers UK reporting that almost three quarters (74%) of carers are feeling exhausted and worn out from caring throughout the pandemic.

- Flexible working policies help with work-life balance allowing staff to vary hours but there are differences in how policies are perceived/implemented.

[33] Carers UK (2021). State of Caring 2021 in Northern Ireland
[34] Carers UK (2021). State of Caring 2021 in Northern Ireland
[35] Carers UK (2021). State of Caring 2021 in Northern Ireland

- Flexible working policies are designed to help staff, but not facilitating requests could adversely impact on females as they tend to be the main carers. Men additionally have caring responsibilities and so not facilitating flexible working requests could impact on them negatively too. The refusals tend to be based the needs of the service rather than finding out why someone needs a change or wants compressed hours etc.

- When staff are dealing with an end-of-life situation in their own personal circumstances, there is no allowance for that as well as when they are caring for someone. Need to look at bereavement and how to support staff and keep them in employment.

Marital Status

What we found

- Results from the 2011 Census indicate that almost half the population i.e. 48% of those aged 16 or over were married and over a third (36%) were single. Approximately 1,200 (0.1%) in 2011 were registered in same sex civil partnerships.[36]
- Lone parents are more likely to be living in poverty and experiencing poorer physical and mental health[37]
- People who are widowed or experiencing relationship breakdown in later life more likely to identify with physical and mental health problems, alcohol abuse, gambling problems, more likely to become homeless[38]

[36] NISRA (2011). Census 2011. Available at: www.nisra.gov.uk/statistics/census/2011-census (Accessed: 28 November 2022)
[37] Joseph Rowntree Foundation (2022). Poverty in Northern Ireland 2022.
[38] Local Government Association (2017). The Impact of Homelessness on Health – A Guide for Local Authorities.

- Research referenced by the Royal College of Nursing indicates that :
- 41% of homeless people reported a long-term physical health problem (compared to 28% of the general population)
- 45% of homeless people had been diagnosed with a mental health problem (compared to 25% of the general population)
- 36% of homeless people had taken drugs (compared to 5% of the general population)[39]

- Research provided by Crisis on homeless mortality in England indicates :
- The average age of death for a homeless person was 47 years for men and 43 years for women compared to 77 years for the general population.
- Drug and alcohol abuse are particularly common causes of deaths amongst the homeless population, accounting for over a third of all deaths.
- Homeless people are more than nine times more likely to commit suicide than the general population.[40]

What you told us:

- Access to appropriate HSC services to support people experiencing homelessness, including due to marital breakdown, and issues around discharge of homeless people from hospital services into the community. Consideration should also be given to their access to dental services and GPs. There is a need for emergency care at the point of need to support the homeless population.

[39] Royal College of Nursing (2021). RCN Bulletin :Homelessness, May 2021.
[40] CRISIS (2021). Homelessness: A Silent Killer.

Political Opinion

What we found:

- There is a correlation between political opinion, health inequalities and negative impacts on health outcomes as indicated by the measurement of health deprivation for the population within Northern Ireland. Based on the NIMDM 2017 health deprivation and disability domain indicators of preventable deaths, health-related welfare benefits, cancer registrations, emergency admission rates, low birth weight babies, children's dental extractions, multiple prescriptions on a regular basis, long-term health or disability and a mental health disorder, the most health- deprived constituencies in Northern Ireland are Belfast West, Foyle and Belfast North. Belfast West (Sinn Fein) – 56% of its SOAs are nested in the top decile of the most deprived SOAs in N.I.Foyle (SDLP) – 30% of its SOAs are nested in the top decile of the most deprived SOAs in N.I. Belfast North (Sinn Fein) – 29% of its SOAs are nested in the top decile of the most deprived SOAs in N.I.[41]
- Of the 20 most deprived SOAs on the health domain (NIMDM) 2017-18 are located in Belfast parliamentary constituencies – Belfast West (10 SOAs); Belfast North (8), the remaining (2) most deprived SOAs are located in Foyle parliamentary constituency.[42]
- In Northern Ireland over the period July – December 2021, 7,404 households presented as homeless. The Local Government Districts (LGD) with the highest number of ' households presenting as homeless' per 1,000 population were Belfast - 6.2 per 1,000, Derry City & Strabane – 6.2 per 1,000, Mid & East Antrim - 4.5 per 1,000. Of the 7,404 households presenting as homeless July – December 2021, 1,694 (23%)

[41] Northern Ireland Assembly (2018). Multiple Deprivation in Northern Ireland, Research Paper.
[42] Northern Ireland Assembly (2018). Multiple Deprivation in Northern Ireland, Research Paper.

quoted ‘accommodation not reasonable’ as the cause. Of the accommodation not reasonable cases, the largest proportion of ‘presenters’ cited ‘physical health/disability’.[43]

Please note nothing was raised at listening events in relation to political opinion.

Religious Belief

What we found:

- In 2021, the main current religions were: Catholic (42.3%); Presbyterian (16.6%); Church of Ireland (11.5%); Methodist (2.3%); Other Christian denominations (6.9%); and Other religions (1.3%).
- In addition, 17.4% of our population had ‘No religion’ – this is a marked increase on 2011 when 10.1% had ‘No religion’. This indicates the increased secularisation of our population.
- The proportion of the population in Census 2021 with ‘No religion’ ranges from 30.6% in Ards & North Down council to 7.8% in Mid Ulster council. All councils are more secular in 2021 than they were ten years ago.
- Combining current religion and religion of upbringing gives 45.7% of our population who were ‘Catholic’, 43.5% who were ‘Protestant, Other Christian or Christian related’ and 1.5% who were from other non-Christian religions.

[43] DFC; NISRA; Housing Executive (2021). Northern Ireland Homelessness Bulletin, July – December 2021.

- The remaining 9.3% of our population, or 177,400 people in Census 2021 neither belonged to nor were brought up in any religion. This group has increased in size from 2011 when 5.6% or 101,200 people were recorded in this way.[44]
- 43% of looked after children/children in care come from the most deprived areas – correlation to religious background of population of most deprived areas. Children in the most deprived areas will experience health and social inequalities, such as lower life expectancy; higher suicide rates; higher rates of mental ill health, with more mood and anxiety disorders and more instances of self-harm; higher rates of alcohol-related deaths and higher drug-related deaths.[45]
- Areas with predominantly Catholic populations have among the highest poverty rates. Children born into areas with high levels of poverty can expect to live for less years and in poorer health than those children born into areas with low levels of poverty.[46]

Please note nothing was raised at listening events in relation to religious belief.

Racial group (ethnicity)

What we found:

- On Census Day 2021, 3.4% of the population, or 65,600 people, belonged to minority ethnic groups. This is around double the 2011 figure (1.8% – 32,400 people) and four times the 2001 figure (0.8% – 14,300 people). Within this 3.4%, the largest groups were Mixed Ethnicities (14,400), Black (11,000), Indian (9,900), Chinese (9,500), and Filipino (4,500). Irish Traveller, Arab, Pakistani and Roma ethnicities also each constituted 1,500 people or more.

[44] NISRA (2021). Census 2021. Available at: https://www.nisra.gov.uk/statistics/census/2021-census. (Accessed: 28 November 2022)
[45] Department of Health and DE (2021). A Life Deserved: "Caring" for Children and Young People in Northern Ireland, February 2021.
[46] Joseph Rowntree Foundation (2022). Poverty in Northern Ireland 2022.

- The number of requests received by the Northern Ireland Health and Social Care Interpreting Service has risen from 63,868 in 2011/12 to 132,434 in 2019/20 showing the increasing demand on services responding to a greater diversity in the population.
- On Census Day 2021, 4.6 percent (85,100 people) of our population aged 3 and over had a main language other than English. Of the 85,100 people who did not have English as their main language, around three-quarters (76.3% or 64,900 people) could speak English well or very well. Thus, just over 20,200 people, (1.1%) of the population, did not have English as their main language and could not speak English well or not at all.
- In 2021 the most prevalent main languages other than English were Polish (20,100 people), Lithuanian (9,000), Irish (6,000), Romanian (5,600) and Portuguese (5,000).
- Census 2021 shows that 12.4 per cent (228,600 people) of our population aged 3 and over had some ability in the Irish language.
- Census 2021 shows that 10.4 per cent (190,600 people) of our population aged 3 and over had some ability in the Ulster-Scots language [47]
- The Roma community are amongst the most deprived and have poor health outcomes. The majority of the Roma population are not vaccinated. [48]
- Poor life expectancy and high levels of suicide persist for the Irish Traveller community. An additional barrier identified for this ethnic group is digital exclusion. [49]
- Issues with language and communication barriers including availability and usage of translation and interpreting services.[50]

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[47] NISRA (2021). Census 2021 Available at: https://www.nisra.gov.uk/statistics/census/2021-census. (Accessed: 28 November 2022)
[48] Wright, D. (2020) Roma Health and Wellbeing in Northern Ireland. Available at: Roma Health and Wellbeing in Belfast (hscni.net) (Accessed 28 November 2022)
[49] Kelleher, C. et al (2010): All Ireland Traveller Health Study.

- Eligibility and access to free services continues to be barrier for those most in need. Unfamiliarity and a lack of understanding of the health system in Northern Ireland. [51]
- Maternal and infant mortality is also an issue for some ethnic groups, including asylum seekers and refugees.[52]
- The NHS has one of the most ethnically diverse workforces in the public sector – research highlights key issues include lack of recognition of culture; concentration in low paid employment; low expectations; recognition of qualifications, lack of English language skills and problems in accessing childcare. [53]
- More than 1 in 8 staff reported experiencing discrimination at work in 2020. [54]
- Lack of ethnic data and monitoring in relation to racial group to enable policy-makers and health care professionals to identify the specific needs of different ethnic groups and develop targeted strategies.[55]
- The review found evidence of NHS ethnic minority staff enduring racist abuse from other staff and patients and this was particularly stark for Black groups. Most of the qualitative studies on experiences of racist abuse in the NHS workforce have been undertaken with nurses (and particularly Black African nurses or those that have been internationally recruited). [56]
- The Covid-19 pandemic has had a disproportionate impact on ethnic minority communities, who have experienced higher infection and mortality rates than the white population. Geography, deprivation,

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[50] Department of Heath for NI (2022). Health Inequalities Annual report 2022.
[51] Northern Ireland Affairs Committee (2021). Minority ethnic and migrant communities experience in Northern Ireland examined.
[52] ECNI (2022), Shadow Report to the Advisory Committee for the framework Convention for the Protection of National Minorities on the Fifth Monitoring Report of the United Kingdom.
[53] The Kings Fund (2020). Workforce Race inequalities and inclusion in NHS providers.
[54] NHS Employers and Nuffield Trust (2021). Attracting, supporting and retaining a diverse NHS workforce.
[55] ECNI (2022), Shadow Report to the Advisory Committee for the framework Convention for the Protection of National Minorities on the Fifth Monitoring Report of the United Kingdom.
[56] NHS Race and Health Observatory (2022). Ethnic Inequalities in healthcare: A Rapid Evidence Review.

occupation, living arrangements and health conditions such as CVD and diabetes accounted for a large proportion, but not all, of the excess mortality risk of Covid-19 in ethnic minority groups.[57]

- The Equality Commission's most recent Equality Awareness Survey (2018) found that all five of the most negatively viewed groups were racial groups: Irish Travellers, Roma, asylum seekers and refugees, migrant workers and minority ethnic groups. Travellers, Roma, migrant workers and minority ethnic groups were also the equality groups with the highest proportions of respondents who 'would mind' them as a work colleague, a neighbour or as an in-law.[58]
- In addition to harassment at work, research suggests that key issues include lack of recognition of culture; concentration in low grade, low paid employment; low expectations; recognition of qualifications, lack of English language skills, problems in accessing childcare, gaps in legal protection, exploitation and forced labour.[59]
- All public bodies including Government departments and agencies need robust information to monitor inequalities, develop evidence-based policy and to plan service delivery. Without ethnic monitoring, Government departments and agencies will find it difficult to identify gaps and monitor whether racial equality work is having any impact.[60]
- Need for the development of a system for monitoring health inequalities experienced by ethnic minorities, including the comprehensive collection and review of data also by S75 category so that any adverse impacts of access outcomes can be identified and addressed.[61]

[57] Office for National Statistics (2020). Coronavirus (COVID-19) related deaths by ethnic group, England and Wales, 2 March to 10 April 2020.
[58] ECNI (2018). A Question of Attitude.
[59] ECNI (2022), Shadow Report to the Advisory Committee for the framework Convention for the Protection of National Minorities on the Fifth Monitoring Report of the United Kingdom.
[60] OFMDFM (2015). Racial Equality Strategy 2015-2025.
[61] ECNI (2022), Shadow Report to the Advisory Committee for the framework Convention for the Protection of National Minorities on the Fifth Monitoring Report of the United Kingdom.

What you told us:

- People from ethnic minority groups have different needs, cultures and can have difficulty accessing services especially if they also have multiple identities across Section 75 (S75) categories such as disability or if they are an older person and/or a carer.

- Need to reach out to the Traveller community re the prevalence of mental health and incidents of suicide.

- The Roma community was highlighted as vulnerable – Roma population across NI is higher than it has been over the past 3-5 year. Teenage pregnancy and difficulties in accessing GPs of particular concern.

- There are other health inequalities amongst the ethnic minority communities such as sickle cell disease in the African community or diabetes in the Indian community. Consider specific communication around these diseases.

- For ethnic minorities there could be multiple barriers: literacy skills to access information, lack of technology e.g. smartphone, language barriers, interpreting requirements. Consider simplifying communication e.g. use of animation to deliver information on specific diseases relevant for the Roma community

- Intersectionality is important. Even as a model, this needs to be in the overall plan and aligned and tied together so people can see themselves and multiple diversities. It is important to help people to navigate this. We need to think about ethnicity and intersectionality across S75 and people identifying as more than one S75 category.

- Regarding data monitoring, guidance is there but it is not applied with consistency. As a result, there is no knowledge of prevalence of conditions based on ethnicity. Data is needed to inform a population approach to the delivery of services. A recent report by Dr A Russell on ethnic monitoring will be a useful tool.

- If you look at the last census, a lot has changed significantly in the NI population with lots of other people from other countries and communities living here - dual approach of proactive education and data analysis required.

- Disconnect between what is happening in terms of ethnicity - add Covid and Brexit-related issues. When people are waiting for their S2 letters, they may be asked to pay for health care, when it is actually free for them.

Sexual orientation

What we found:

- Approximately 1,200 (0.1%) in the 2011 Census were registered in same sex civil partnerships.[62]The Office for National Statistics (ONS) have indicated that in 2020 some 1.4% of the household population in Northern Ireland identify as LGBT.[63]

- A National LGBTQ+ survey showed that 38% of service users surveyed had had a negative experience due to of their sexual orientation. A total of 27% were worried, anxious or embarrassed about going to a GP.[64]

- COVID-19 has had an impact on sexual and gender minority populations with their mental health and well-being, health behaviours, safety, social connectedness and access to routine healthcare all showing poorer or worse outcomes than comparators[65]

[62] NISRA (2011). Census 2011. Available at: www.nisra.gov.uk/statistics/census/2011-census (Accessed: 28 November 2022)
[63] Office for National Statistics, (2022). Sexual Orientation, UK. Available at: https://www.ons.gov.uk/ (Accessed: 28 November 2022)
[64] NHS England (2021). LGBT health 2021. Available at: www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/lgbt-health/ (Accessed :28 November 2022)

- LGBTQ+ staff experience abuse and discrimination in the workplace - over 70 per cent had experienced homophobic or biphasic abuse at their place of work or study. [66] LGBTQ+ Doctors report one or more types of harassment due to their sexuality.[67]
- Research by NHS Digital, which shows that 2.7% of the workforce describe their sexual orientation as LGBTQ+, 69.8% as heterosexual, and 27.5% of staff, chose not to share this information. The high percentage of staff who do not share their sexual orientation would indicate that key data is not captured to support actions to address inequalities.

What you told us:

- For transgender services, the regional Knowing Our Identity (KOI) service, which supports trans and gender variant children and adolescents up to the age of 18, is not taking any service referrals. There is nothing there for transgender young people at present.

General comments not related to specific Section 75 categories

1. **Financial inequalities for HSC staff and our communities**

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[65] McGowan, V. J.; Lowther, H.J. and Meads, C. (2021). Life under COVID-19 for LGBT+ people in the UK: systematic review of UK research on the impact of COVID-19 on sexual and gender minority populations. Available at: Life under COVID-19 for LGBT+ people in the UK: systematic review of UK research on the impact of COVID-19 on sexual and gender minority populations - PubMed (nih.gov) (Accessed: 28 November 2022)
[66] British Medical Association (BMA) (2022). Sexual orientation and gender identity in the medical profession. Available at: https://www.bma.org.uk/media/6340/bma-sogi-report-2-nov-2022.pdf (Accessed: 28 November 2022)
[67] British Medical Association (BMA (2021). Take pride in work against discrimination – but more needs to be done. Available at: https://www.bma.org.uk/news-and-opinion/take-pride-in-work-against-discrimination-but-more-to-be-done (Accessed: 28 November 2022)

- Staff, across all grades and bandings, who were previously working from home are incurring the increase in petrol costs to drive to work and increase in childcare costs etc. There could be more accessible employer childcare provisions.
- The financial impact and cost of living impact on service users should be considered. This can be seen when organising events or meetings; can people afford to get there or pay for parking etc. when it is not a virtual meeting.

Identifying key themes

The identified themes below focus on inequalities in health and social care experienced by those protected in law by the equality and good relations duties of Section 75 of the Northern Ireland Act 1998.

The broad themes from which we have considered targeted actions to address key inequalities and promote equality of opportunity and good relations, will support the health and social care system to address inequalities in access to services and employment. These themes were consistently reinforced through our engagement.

When this Audit is made available on our websites, it is likely that new information will be emerging and will continue to do so. This document should be viewed as a living document, which will be subject to change. Trusts are committed to regularly reviewing relevant literature and ongoing engagement.

1. Improving the data, we use to support decision-making

We know that high quality data plays a role in improving services and decision-making. When Trusts have good population data, they can identify areas that have worse health outcomes and target health and care resources

to reduce health inequalities. Feedback from consultees has indicated that we need to improve that data we collect in relation to health and social care inequalities.

2. Addressing barriers to accessing health and social care

While much work has been done to date to promote equality of opportunity, it remains the case that there are a number of equality groups that continue to face particular and unique barriers. During the listening events, we heard many suggestions on how to improve equality of access to health and social care services. Actions have been developed in response to what we have heard and are aimed at providing welcoming, person-centred and accessible services for everyone.

3. Supporting Our Staff

We know that staff are our most valuable resource and the health and social care system in Northern Ireland is indebted to the work that they do every day and in particular, throughout the pandemic. We are committed to celebrating and embracing diversity amongst our staff and to ensuring that they feel able to bring their authentic selves to work so that they feel valued and can continue to provide safe, effective and compassionate health and social care services.

4. Supporting informal/family carers

We know that many of us are likely to become a carer at some point in life and that informal carers cover a great part of care needs, often called the ‘invisible workforce’. Strengthening the voice and representation of informal

carers is the first step to address the challenges facing informal carers. Informal care can be physically and mentally demanding, leading carers to often feel exhausted, lonely, and strained.

5. Partnership working

A new Integrated Care System (ICS) is currently being developed for Northern Ireland. This system signals a new way of planning and managing our health and social care services based on the specific needs of the population. The ICS approach harnesses the strengths in our existing partnerships and focuses on addressing the wider determinants of health and wellbeing through a population health approach.

We have developed our Equality Action Plan to reflect the themes identified and developed associated actions and outcome measures to address the prioritised inequalities.