Equality and Human Rights Screening Template

The PHA is required to address the 4 questions below in relation to all its policies. This template sets out a proforma to document consideration of each question.

What is the likely impact on equality of opportunity for those affected by this policy, for each of the Section 75 equality categories? (minor/major/none)

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

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

Are there opportunities to better promote good relations between people of a different religious belief, political opinion or racial group?

For advice & support on screening contact:

Anne Basten
Equality Unit
Business Services Organisation
2 Franklin Street
Belfast BT2 8DQ
028 95363961
email: Equality.Unit@hscni.net

SCREENING TEMPLATE

See Guidance Notes for further information on the ‘why’ ‘what’ ‘when’, and ‘who’ in relation to screening, for background information on the relevant legislation and for help in answering the questions on this template .

(1) INFORMATION ABOUT THE POLICY OR DECISION

1.1 Title of policy or decision

The Public Health Agency – Partnership and Engagement Strategy 2025-2030

1.2 Description of policy or decision

what is it trying to achieve? (aims and objectives)

The Public Health Agency’s (PHA) Partnership and Engagement Strategy (2025-2030) reflects the integration of two key programmes of work led by PHA

1- Regional Personal and Public Involvement (PPI)
2- Regional Patient Client Experience (PCE) programmes,

The strategy sets out one integrated plan which outlines how the PHA and the wider HSC further embeds approaches in Experience and Involvement into the culture and practice of the HSC. This is consistent with the PHA Corporate plan which states:

“Protect and improve the health and wellbeing of people, and reduce health inequalities, by working in partnership with individuals, communities, and organisations from the public, private, and voluntary sectors.”

The strategy is built upon the vision of the Partnership and Engagement team which is:

“To make partnership and engagement working essential to Health and Social Care in a way that supports a healthier population.”

- **how will this be achieved? (key elements)**

The Strategy reflects a renewed commitment within the PHA to working in partnership through the two distinct functions of Experience and Involvement programmes, working in partnership with service users, carers, families, communities and the wider public, in our commitment to improve Public Health.

Through this strategy we aim to:
“Work in partnership with service users, carers, families, the wider public, PHA and HSC partners, to enable people to work together, to influence and inform meaningful change in our Health and Social Care system."

This will be achieved through commitments in the following priority areas

1- Provide Strategic Leadership
2- Build understanding, knowledge and skills
3- Engage and connect
4- Identify and demonstrate impact

The strategy echoes strategic policy drivers and related HSC standards including a commitment to the following principles:

1- Collaboration and Partnership
2- Dignity and Respect
3- Transparency and Openness
4- Inclusivity, Equity and Diversity

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

There are no obvious constraints to the adoption of the strategy. Following approval through the agency senior team – AMT, the strategy will go out for public consultation to enable input from all key stakeholders, including service users, carers, families, communities and the public. There is also a commitment to reaching out to groups relating to Health Inequalities and Inclusion Health

1.3 Main stakeholders affected (internal and external)

This strategy directly impacts the Partnership & Engagement team within the PHA, which will be reflected in an overarching action plan and individual workplans, In the development of the strategy a stakeholder map was developed (Appendix 2 P&E Strategy document). Key stakeholders directly involved in the development and delivery of the strategy fall under three broad categories:

- internal PHA directorates;
- external partners and networks;
- service users, carers, families, communities and the public.

Internal PHA directorates

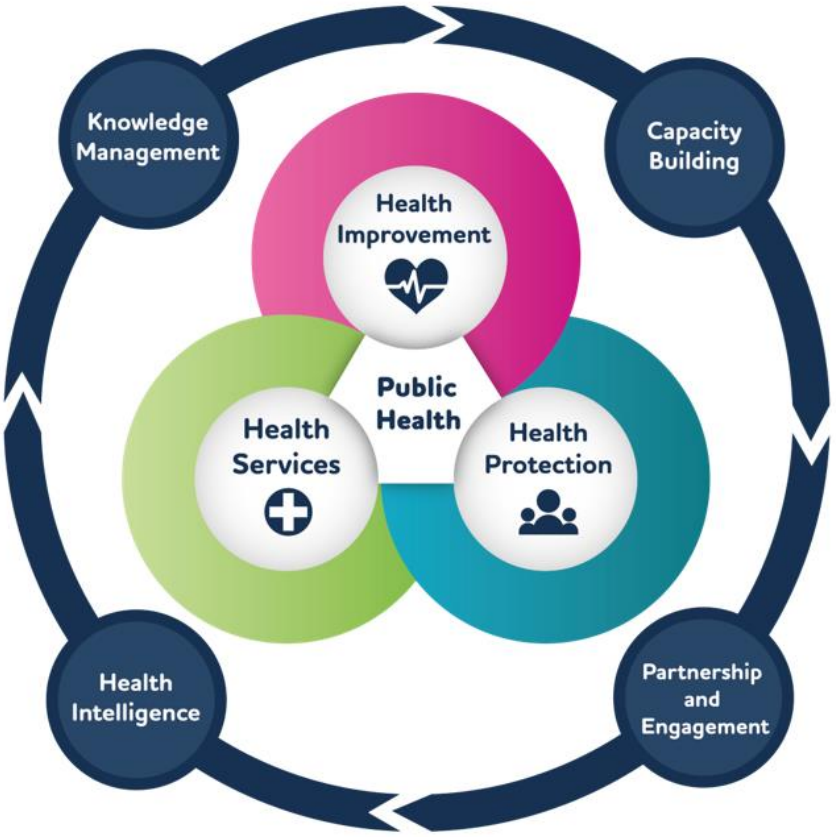
Partnership and engagement is critical for health improvement, health protection and the development and delivery of health services, as illustrated in Figure 1. The partnership and engagement team build upon established and developing internal structures and connections to ensure that the voices of service users, their families and carers, the community and wider public help to inform and shape the priorities for the PHA.

This will be achieved through:

- Leadership, advice and guidance across all PHA directorates and to specific programmes of work.
- Development of a forum whereby staff from across the wider organisation can act as advocates and champions for Partnership & Engagement working through the establishment of our Experience & Involvement Associates model.

•Membership within Public Health Planning Teams (PHPTs). The PHPTs aim to bring together different PHA experts to help make decisions about funding and resources. Each PHPT is supported by a nominated lead from the partnership and engagement team and has shaped the approach adopted by each PHPT.

Figure 1. Relationship of three key domains of public health with partnership and engagement



External partners and networks

Outside the PHA, the partnership and engagement team provides regional strategic leadership and advice through regional groups across HSC organisations. These include amongst other fora:

- Regional HSC PPI Forum.
- Regional PPI Leads Group.
- Regional PCE Working Group.
- Regional PCE Facilitators Group.

Each regional group is committed to having representation of / engagement from service users, carers and families and reaches out to community and public partners as appropriate to the work they are engaged in.

There is an important and developing relationship with the work of the Patient Client Council (PCC). The work of PCC compliments the PHA focus on experience and involvement within HSC organisations, staff and services. Effective and enhanced collaboration with colleagues in PCC is an important part of the cultural change we seek to embed in the HSC.

Service users, carers and families

Central to the design and delivery of the strategy are the voices of service users, carers and families. To achieve this, the partnership and engagement team supports meaningful engagement in a number of ways:

- Regional PPI forum: Service users, carers and families are represented on the Regional HSC PPI Forum, which is co-chaired by a service user/carer. There are 15 representatives on the forum from across the region with each service user representative reaching out to a larger network across the HSC.
- Peer Mentor: Through a dedicated Peer Mentor lead, peer mentoring enables individuals with lived experience to support and guide others. This fosters trust, support and shared learning.
- Service User Reference Group: This group offers an opportunity for people to influence the strategic direction of the HSC. This includes equipping service users and carers with knowledge and skills necessary to engage with confidence in the commissioning, design, development and evaluation of services.

As key stakeholders each forum will have an opportunity to inform the implementation and evaluation of this strategy, ensuring it is responsive and grounded in the insights of those with lived experience.

Another core component of partnership and engagement is the consultation process. As set out in the Health and Social Care Reform Act (NI) 2009, consultation with service users and carers is a statutory requirement in the commissioning, development, design and delivery of Health and Social Care (HSC) Services.

All HSC organisations, including the PHA, have developed an Involvement & Consultation scheme which is now in place and sets out how they meet their statutory responsibilities in this field. This scheme underpins PHA commitment to strong partnerships with individuals, communities and other key public, private and voluntary organisations and is supported through the partnership and engagement strategy.

Key areas of work that the PHA progresses, whether that be through the PHPTs or through other approaches, will be in line with the Partnership & Engagement Strategy to commit the embedding of Experience & Involvement into their way of working.

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

Alongside PHA Corporate plan, there are a number of key strategic drivers which have informed the development of the strategy. These directly affect how we explore people’s lived experience and empower them to become involved in the commissioning, development and delivery of services.

Guidance on strengthening personal and public involvement in Health and Social Care (2007)
This Departmental circular first introduced PPI as a key concept and integral

component of the quality agenda. By encouraging partnership working, it aims to improve health and social care service provision in Northern Ireland and the individual experiences of those who use these services.

Health and Social Care Reform Act (2009)
The Act gave all HSC organisations a statutory duty to consult people and involve them to inform and influence the commissioning, planning, delivery and evaluation of HSC services.

Priorities for Action (2010)
Under the direction of the PHA, HSC organisations promote patient client experience standards, including the development of local and regional mechanisms to measure standards through lived experience expressed through stories.

Quality 2020 (2011)
Quality 2020 identified learning through lived experience as a both a driver and a performance measure for quality and safety of services in the HSC. Meaningful engagement and involvement is highlighted as a key priority.

Guidance for HSC organisations on arrangements for implementing effective personal and public involvement policy in the HSC (2012)
This Departmental circular outlines the roles and responsibilities for each organisation. This includes PHA responsibility for leading implementation of PPI policy across the HSC and for the oversight role it has, in regards to HSC Trusts meeting their PPI statutory and policy responsibilities.

The Co-production Guide (2018)
The HSC was further directed to move towards a co-production approach to transform health and social care provision as set out in Delivering Together 2026.

The Change and or Withdrawal of Services – Roles & Responsibilities Circular (2025)
This updated Circular, set out steps required by various HSC bodies and clarified roles and responsibilities when it comes to change or withdrawal of services and the relationship with statutory and policy responsibilities in regards to the involvement of those potentially affected by such decisions.

The P&E Strategy and associated action plan is also responsive to ongoing reforms and innovations across the HSC. Each of these strategic developments are drivers in encouraging collaboration, active listening and learning from the people we serve.

•The Being Open Framework (led by the Department of Health [DoH]) outlines the essential need for transparency and honesty with service users and carers through all interactions, from routine conversations to formally responding to adverse incidents.

•The Development of Patient Safety Culture Framework (led by RQIA) focuses on system-wide learning and continuous improvement, making service user and carer involvement integral to safer care delivery.

•**Creating a New Approach to Integrated Care System [ICS] (led by DoH)** removes barriers between services and encourages collaboration with service users, their families and carers as equal partners. This is achieved through Regional ICS service user forum and Area Integrated Partnership Boards (AIPB).

•**Reshape and Refresh (led by PHA) details the modernisation of the PHA's role**, placing a greater emphasis on strengthening public health through a collaborative, multidisciplinary approach. This work is grounded in collaboration with communities and key stakeholders to protect the public, tackle health inequalities and enhance health services for everyone in Northern Ireland throughout all stages of life.

•**Strategic approach to public engagement (led by DoH)** explores the wider context of public engagement across all HSC organisations and arm’s length bodies. This work will seek to offer clarity around roles and responsibilities, highlight areas of best practice for public engagement and identify the areas for improvement.

- **Other related strategic policy drivers**:
- 2010 Equality Act Circular
- 2014 PHA PPI Strategy in HSC Research
- 2014 Right Place Right Time
- 2012 and 2016 PPI Strategy
- 2016 Systems, Not Structures - Changing Health and Social Care
- 2016 Programme for Government
- 2016 Health and Wellbeing (2026 Delivering Together)
- 2021 Enhance Clinical Care Framework Care Home NI
- 2022 Shared Decision-Making Nice Guidance and Circular

(2) CONSIDERATION OF EQUALITY AND GOOD RELATIONS ISSUES AND EVIDENCE USED

2.1 Data gathering

What information did you use to inform this equality screening? For example previous consultations, statistics, research, Equality Impact Assessments (EQIAs), complaints. Provide details of how you involved stakeholders, views of colleagues, service users, staff side or other stakeholders.

This strategy was informed by work with members of the Regional HSC PPI Forum, who had input into its development over a 2 year period. This Forum is made up of members of HSC Trusts and Regional bodies from across the HSC alongside service users and carers. Input from this forum was enabled through Regional workshops which focused upon the integration of the two programme areas of Experience and Involvement and produced an indicative Partnership & Engagement Strategy.

Forum members had opportunities both during the workshops and through sharing of a number of iterations of the draft strategy, to contribute, inform and shape the development of the strategy and also to inform the equality screening.

The views and opinions of this forum and the networks of people and organisations with which they are associated, have been key to the final draft version of the Strategy which is being taken to public consultation

Specific to PHA other data considered included PHA Corporate plan, Annual Business Plans and Directorate Plans, Health Survey NI Results, Health Inequalities Annual Report 2024 and Equality screenings.

Specific to the work within Partnership and Engagement data was garnered from previous PPI strategies, Priorities Action plan for Experience programme, Annual Complaints report, 10,000 MORE Voices reports and Care Opinion Annual Reports.

It is recognised that the outworking of this strategy impacts upon both the staff across PHA and also the interface with the population of Northern Ireland as explored under Section 75 in the following section.

2.2 Quantitative Data

Who is affected by the policy or decision? Please provide a statistical profile. Note if policy affects both staff and service users, please provide profile for both.

Category	***What is the makeup of the affected group? (%) Are there any issues or problems? For example, a lower uptake that needs to be addressed or greater involvement of a particular group?***
Gender	At 30 June 2023, Northern Ireland's population was estimated to be 1.92 million people. Between mid-2022 and mid-2023, the population of Northern Ireland increased by 9,800 people (0.5 per cent). Just over half of the population (50.8 per cent) were female, with 974,900 females compared to 945,500 males (49.2 per cent). (NISRA Statistical Bulletin 2023) The census day population comprised of 967,000 females and 936,100 males. This means that for every 100 females in Northern Ireland there were 96.8 males. (Census 2021) The Gender Identity Research & Education Society (GIRES) highlights the following Office for National Statistics (ONS) 2021 UK Census question which asked people aged over 16: "Is the gender you identify with the same as your sex registered at birth?" 45.7 million (94.0% of the UK population aged 16 years and over) answered the question: • 45.4 million (93.5%) "Yes" • 262,000 (0.5%) "No" • 1.9 million (6.0%) did not answer the question.

	Several factors may have reduced the number of “No” responses as the Census can be completed by a single family member for a whole household. Consequently, some trans and gender diverse people may not have been able to answer the question themselves. Others may not have felt it was safe to do so. Of the 262,000 people (0.5%) who answered “No”, indicating that their gender identity was different from their sex registered at birth: • 118,000 (0.24%) answered “No” but did not provide any further information • 48,000 (0.10%) identified as a trans man • 48,000 (0.10%) identified as a trans woman • 30,000 (0.06%) identified as non-binary • 18,000 (0.04%) wrote in a different gender identity Data from other sources indicate that the Census figures may understate the size of the trans and gender diverse population. The Gender Identity Research and Education Society (GIRES) estimate the number of gender nonconforming employees and service users, based on the information that GIRES assembled for the Home Office (2011) and subsequently updated (2014): • gender variant to some degree 1% • have sought some medical care 0.025% • having already undergone transition 0.015%. The numbers who have sought treatment seems likely to continue growing at 20% per annum or even faster. Few younger people present for treatment despite the fact that most gender variant adults report experiencing the condition from a very early age. Yet, presentation for treatment among young people is growing even more rapidly (50% p.a.). Organisations should assume that there may be nearly equal numbers of people transitioning from male to female (trans women) and from female to male (trans

	men). Applying GIRES figures to NI population (using NISRA mid-year population estimates for June 2018) N=1,881,600: • 18,816 people who do not identify with gender assigned to them at birth • 470 likely to have sought medical care • 282 likely to have undergone transition. A 30-Country Ipsos Global Advisor Survey reflects 3.1% of people saying they were trans, non-binary, gender queer or gender fluid, Agender or another gender that was not male or female Ipsos Global Advisor | LGBT+ Pride 2023 PHA Workforce (as recorded Sept 2024) • Male 23.75% • Female 76.25% • Transgender – 0 Percentages based upon Staff in post (Sept 2024) • 361 (permanent HC) • 336.81 (permanent WTE) • 43 (temporary HC) • 36 (temporary WTE)
Age	Census 2021 Population Statistics reflect there are 365,200 children in Northern Ireland aged 0 to 14, a 10,500 increase compared from the 354,700 children in 2011. In contrast the number of persons aged 65 and over has increased from 263,700 in 2011 to 326,500 in 2021. The ageing of the population can also be seen in the median age of the population (the age at which half the population are above or below), which over the last decade has increased by two years from 37 in 2011 to 39 in 2021. Children (defined as those aged 0 to 14) make up 19.2% of the Northern Ireland population. This percentage varies across Local

	Government Districts and is highest in Mid Ulster where the proportion is 21.7%, and lowest in Ards and North Down where the proportion is 17.0%One in eight children and young people in Northern Ireland experienced emotional difficulties, one in ten had conduct problems and one in seven problems with hyperactivity. (The Executive Summary of the Youth and Wellbeing Prevalence Survey 2020) People over 60 make up 19% of the population, according to Census 2021. This represents a near 25% increase from 2011 and demonstrates the scale of population change due to ageing. People aged 65 and over account for 326,500 people or 17.2% of the Northern Ireland population. (Census 2021) The number of people aged 85 and over in Northern Ireland was estimated to be 39,500 in mid-2020, an increase of 700 people (1.9 per cent) since mid-2019. Over the decade, the population aged 85 and over grew by 8,700 people (28.1 per cent) (Census Bulletin 2021) By mid-2027, the number of people aged 65 and over is projected to overtake the number of children. By mid-2045, almost 1 in 4 people in Northern Ireland are projected to be aged 65 and over (NISRA Bulletin 2020) The number of people aged 65 and older will grow from 17.8% in 2023 (342,482 total individuals) to 25.8% in 2050 (499,337 total individuals) The number of people aged 65 and over will, on average, grow annually by 7,409 individuals until 2040, and in the period 2024 to 2034, it will grow by 8,517 individuals on average every year. (NISRA 2020 and 2023 Statistics) In 2022/23 the percentage of primary 1 pupil in the most deprived areas affected by obesity was more than double the proportion in

	the least deprived areas. The inequality gap in year 8 pupils affected by obesity was slightly lower, with the proportion in the most deprived areas 94% higher than in the least deprived areas. (Health Inequalities Annual Report 2024, DOH) NI Age Profile Band /Population/ (Percentage) • 0-14 :365,200 (19.2%) • 15-64 :1,211,500 (63.7%) • 15-39 :594,400 (31.2%) • 40-64 :617,100 (32.4%) • 65+ :326,500 (17.2%) • 65-84 :287,100 (15.1%) • 85+ :39,400 (2.1%) (Census 2021) PHA Workforce (Sept 2024) Age Group % • 16-24 6.21% • 25-29 7.52% • 30-34 5.51% • 35-39 9.12% • 40-44 8.52% • 45-49 10.32% • 50-54 12.83% • 55-59 14.73% • 60-64 11.42% • >=65 13.83%
Religion	In Northern Ireland, the main current religions are Catholic (42.3%), Presbyterian (16.6%), and Church of Ireland (11.5%). Other Christian denominations and other religions make up the remaining 24.7. (Census Bulletin; Religion 2021)

In addition, 17.4% of the population had ‘No religion’ – this is a marked increase on 2011 when 10.1% had ‘No religion’. This points to the increased secularisation of our population.

Religion or Religion brought up in the 2021 Census, regarding religious background, highlights four of the six NI counties had a Catholic majority and two had a Protestant majority. Just under one person in five (19.0%) either had ‘no religion’ (17.4%) or ‘religion not stated’ (1.6%). The equivalent percentages for the main religions were:

- Catholic (42.3%)
- Presbyterian Church in Ireland (16.6%)
- Church of Ireland (11.5%)
- Methodist (2.4%)
- Other Christian denominations (6.9%)
- Other non-Christian Religions (1.3%)

Census Statistics 2021

Bringing together information on current religion and religion of upbringing, 45.7% of the population were either Catholic or brought up as a Catholic, while 43.5% were recorded as ‘Protestant and other Christian (including Christian related)’. Again, bringing together information on current religion and religion of upbringing, 1.5% of the population are classified as ‘other religions’ and 9.3% of the population identified that they neither belonged to nor were brought up in a religion (‘None’).

PHA Workforce (Sept 2024)

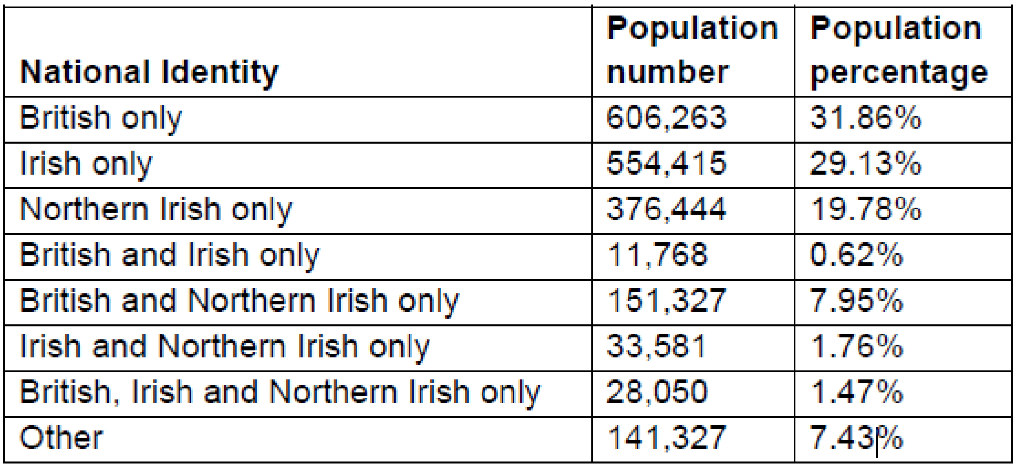
- Perceived Protestant 1.35%
- Protestant 15%
- Perceived Roman Catholic 0.74%
- Roman Catholic 18.02%
- Neither 0.83%
- Perceived Neither 0%
- Not assigned 64.06%

Political Opinion

63% of the population voted in the 2022 NI Assembly election. Of these 29% voted Sinn Fein, 21% DUP, 14% Alliance, 11% UUP, and 9% SDLP

(BBCNI).

The 2021 Census showed National identity (person based) number and percentage:



National Identity	Population number	Population percentage
British only	606,263	31.86%
Irish only	554,415	29.13%
Northern Irish only	376,444	19.78%
British and Irish only	11,768	0.62%
British and Northern Irish only	151,327	7.95%
Irish and Northern Irish only	33,581	1.76%
British, Irish and Northern Irish only	28,050	1.47%
Other	141,327	7.43%

According to research (2019) half of the population of Northern Ireland describe themselves as "neither unionist nor nationalist"

(BBCNI)

Just over a quarter (26%) replied that they considered themselves to be unionists, while just over a fifth (21%) described themselves as nationalists.

The responses were also broken down by gender, religious background and age. There was only a 2% difference between the proportion of men and women who identified as nationalist (22% and 20% respectively).

Among unionists, there was a gap of eight percentage points between men and women, with 31% of men describing themselves as unionist, compared with 23% of women. In terms of age, the group most likely to pick a side in the border debate was pensioners aged 65 and over, while people under the age of 45 were more likely to say there were neutral on the union.

The age group with the highest number of neutrals was the 35 to 44-year-olds' bracket, outstripping their younger 25 to 34-year-old peers by 10 percentage points.

The youngest age bracket (between 18 and 24 years old) also had a high number of neutrals, with 59% saying they were neither unionist nor nationalist. However, in that age group young unionists outnumbered young nationalists significantly, with a quarter of 18 to 24-year-old respondents describing themselves as unionist, and just 14% who said they were nationalists. At the other end of the scale, there was an even bigger political split between the over 65s. Just under a fifth (19%) of pensioners described themselves as nationalist while more than twice that number (41%) replied that they were unionist. Pensioners were also the least likely to say they were neutral on the union, with just 38% of over-65s falling into that category. As regards religious background, exactly half of the Catholics surveyed identified as nationalist and more than half (55%) of Protestants identified as unionist. People who said they had no religion were most likely to say they had no political affiliation to unionism or nationalism.

Political Attitudes, Research Update update151.pdf

In the above NILT 2022 report, the breakdown of self-described community identities in Northern Ireland is unionist (31%), nationalist (26%) and ‘neither’ (38%)

	PHA Workforce (Sept 2024) • Broadly Nationalist 0.70% • Other 2.30% • Broadly Unionist 0.90% • Not assigned 94.49% • Do not wish to answer 1.60%
Marital Status	46% (693,000 adults) were married or in a civil partnership in 2021. This made up 46% of our population aged 16 and over. In contrast 577,000 adults (38%) were single (never married/civil partnered). Of the adult population living in households, just over half lived as part of a couple within the household (53% or 794,000 people in a married, civil partnership or co-habiting couple). The remaining 695,000 adults (47%), did not live as part of a couple within the household. (NISRA Bulletin) Census 2021 findings highlight following population data: • Single (never married/civil partnered) 576,700 (38.1%) • Married 690,500 (45.6%) • In a civil partnership 2,700 (0.2%) • Separated [note 1] 57,300 (3.8%) • Divorced [note 1] 91,100 (6.0%) • Widowed [note 1] 96,400 (6.4%) *Note 1: These classifications include both the married and civil partnership equivalents. 'Separated' is 'separated (still legally married or still legally in a civil partnership)', 'divorced' is 'divorced or formerly in a civil partnership now dissolved' and 'widowed' is 'widowed or surviving partner from a civil partnership'* (Census, 2021)

	The rise in the ‘single’ population and the fall in the ‘married’ population here is in line with results from recent censuses in England and Wales. These figures mirror changes in society and specifically in personal relationships that has been witnessed over the last 50 years. Northern Ireland Life and Times Survey (2018): • Single (never married) - 32% • Married and living with husband/wife - 51% • A civil partner in a legally-registered civil partnership - 0% • Married and separated from husband/wife - 3% • Divorced - 6% • Widowed - 7% <u>PHA Workforce (Sept 2024)</u> • Divorced 0.40% • Mar/CP 16.93% • Other 0.20% • Separated 0.20% • Single 4.41% • Unknown 77.76% • Widowed 0.10%
Dependent Status	There are over 220,000 people providing unpaid care for a sick or disabled family member or friend in Northern Ireland. Despite the multi-billion-pound savings they deliver here each year, too many local carers are being driven to breaking point by unrelenting caring duties, few opportunities for a break, poverty and patchy support from Health and Social Care services. (A New Deal for unpaid carers in Northern Ireland | Carers UK 2023) CarersNI State of Caring 2023 Annual survey (UK wide, including NI) examines the impact of unpaid caring on health and wellbeing

in Northern Ireland, based on data from Carers NI's State of Caring 2023 survey. It shows:

- 1 in 4 carers in Northern Ireland are suffering mental ill-health
- 50% feel lonely at least some of the time
- 43% identify more breaks as among their main needs as a carer
- More than 1 in 3 have put off health treatment for themselves because of the demands of caring.

State of Caring 2023: The impact of caring on health in Northern Ireland | Carers UK

There are over 290,000 people providing some form of unpaid care for a sick or disabled family member or friend in Northern Ireland – around 1 in 5 adults. (Carers UK, 2022).

Of those participating in the survey:

- 82% identified as female and 17% identified as male.
- 4% are aged 25-34, 17% are aged 35-44, 33% are aged 45-54, 31% are aged 55-64 and 14% are aged 65+.
- 24% have a disability.
- 98% described their ethnicity as white.
- 28% have childcare responsibilities for a non-disabled child under the age of 18 alongside their caring role.
- 56% are in some form of employment and 18% are retired from work. • 31% have been caring for 15 years or more, 16% for between 10-14 years, 25% for 5-9 years, 25% for 1-4 years, and 3% for less than a year.
- 46% provide 90 hours or more of care per week, 13% care for 50-89 hours, 23% care for 20-49 hours, and 19% care for 1-19 hours per week.
- 67% care for one person, 25% care for two people, 5% care for three people and 3% care for four or more people.

The economic value of unpaid care in Northern Ireland | Carers UK

(2023)
People providing unpaid care for sick or disabled family members and friends are saving Northern Ireland's health service £5.8 billion in care costs each year – representing £16 million per day, or £0.7 million per hour.

The value of unpaid care in Northern Ireland has grown by over 40% during the last decade – significantly higher than the equivalent rise in England (30%) and Wales (17%) during the same period.

In total, unpaid carers in Northern Ireland are saving the equivalent of 80% of the DoH's entire day-to-day spending budget for 2023-24.

The annual amount of money saved by unpaid carers is greatest in the Northern Health and Social Care Trust (£1.3 billion), followed by the Belfast Trust (£1.1 billion), Southern Trust (£1 billion), South Eastern Trust (£985m) and Western Trust (£800m).
The economic value of unpaid care in Northern Ireland | Carers UK

Census 2021 data highlights that one person in eight of the population aged 5 or more (or 222,200 people) provided unpaid care to a relative or friend who had a health condition or illness. The 2021 Census notes how many hours the carer provided each week. One person in twenty-five (68,700 people) provided 50 or more hours of unpaid care per week. While people of all ages provided unpaid care, it was most common among those aged 40 to 64, at one person in five (or 124,600 people). • The census also found that 2,600 children aged 5 to 14 provided unpaid care. • The overall number of people providing unpaid care has not changed markedly from Census 2011 to Census 2021. However the number of people providing 50 or more hours unpaid care each week has increased (up from 56,300 people in 2011 to 68,700 people in

	2021) The 2021 census illustrated that in Northern Ireland (usual residents aged 5 and over 1,789,348) the percentage of usual residents aged 5 and over who provide: • No unpaid care 87.58% • 1-19 hours unpaid care per week 5.63% • 20-34 hours unpaid care per week 1.38% • 35-49 hours unpaid care per week 1.57% • 50+ hours unpaid care per week 3.84% <u>PHA Workforce</u> (Sept 2024) Yes 4.01% Not assigned 93.79% No 2.20%
Disability	According to NISRA statistics (Census 2021) nearly one person in every nine in Northern Ireland had a long-term health problem or disability which limited their day-to-day activities a lot (218,000 people). Over half of the population aged 65 or more (56.8% or 185,300 people) had a limiting long-term health problem or disability. In contrast, this falls to just under 8% of those aged 0 to 14. The number of people that had a long-term health problem or disability which limited their day to-day activities increased from 374,600 people in 2011 to 463,000 people in 2021 (or a nearly 25% increase in number over the decade). This level of increase mirrors the ageing of our population. While the overall level of a limiting long-term health problem or disability increased from 20.7% to 24.3%, the largest change is in people whose day-to day activities were limited 'a little' – up from 159,400 people in 2011 to 245,100 people in 2021.

The type of long-term health condition that was most frequently reported (whether solely or in combination with others) was ‘long-term pain or discomfort’ (11.6% of the population or 220,300 people). The least prevalent long-term health condition was ‘Intellectual or learning disability’ (0.9% or 16,900 people).

Out of all usual residents (n=1,903,179), the Percentage of usual residents
whose day-to-day activities are:
- Limited a lot – 11.45%
- Limited a little – 12.88%
- Not limited – 75.67%

('day-to-day activities limited' covers any health problem or disability, including problems related to old age, which has lasted or is expected to last for at least 12 months.)

The 2021 census also set out the following types of long-term condition held by the population:
- Deafness or partial hearing loss 5.75%
- Blindness or partial sight loss 1.78%
- Mobility of Dexterity Difficulty that requires wheelchair use 1.48%
- Mobility of Dexterity Difficulty that limits basic physical activities 10.91%
- Intellectual or learning disability 0.89%
- Learning difficulty 3.5%
- Autism or Asperger syndrome 1.86%
- An emotional, psychological or mental health condition 8.68%
- Frequent periods of confusion or memory loss 1.99%
- Long term pain or discomfort. 11.58%
- Shortness of breath or difficulty breathing 10.29%
- Other condition 8.81%

https://www.nisra.gov.uk/system/files/statistics/census-2021-main-

	statistics-for-northern-ireland-phase-2-statistical-bulletin-health-disability-and-unpaid-care.pdf Health Survey NI (2021-22) findings revealed two-fifths of respondents (41%) have a physical or mental health condition or illness expected to last 12 months or more (similar to 2019/20). This increased with age from 27% of those aged 16-24 to 69% of those aged 75 and over. Half (50%) of those living in the most deprived areas reported a long-term condition compared with less than two fifths (37%) of those in the least deprived areas. Less than a third (29%) of respondents have a long-standing illness that reduces their ability to carry out day-to-day activities (similar to 2019/20). Prevalence increased with age with 13% of those aged 16-24 reporting a limiting long-term condition compared with 56% of those aged 75 and over. Most of those (88%) with limiting long-term conditions reported their ability to carry out day-to-day activities had been reduced for 12 months or more. A RNIB's Community Engagement project demonstrated 72 % of people with sight loss report they cannot read personal health information given to them by their GP. Also 22 % respondents say they have missed an appointment due to information being sent to them in an inaccessible format. (Health Survey NI, 2021-22) PHA Workforce (Sept 2024) No 15.13% Not assigned 83.87% Yes 1.00%

Ethnicity	Census 2021 data highlights that in 2021 the number of people with a white ethnic group was 1,837,600 (96.6% of the population). Conversely, the total number of people with a minority ethnic group stood at 65,600 people (3.4% of the population). Within this latter classification, 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. Summary of 2021 Census Ethnic group • White 1,837,600 (96.60%) • Black 11,000 (0.60%) • Indian 9,900 (0.50%) • Chinese 9,500 (0.50%) • Filipino 4,500 (0.20%) • Irish Traveller 2,600 (0.10%) • Arab 1,800 (0.10%) • Pakistani 1,600 (0.10%) • Roma 1,500 (0.10%) • Mixed Ethnicities, 14,400 (0.80%) • Other Asian, 5,200 (0.30%) • Other Ethnicities 3,600 (0.20%) Census 2021, 4.6 per cent (85,100 people) of NI population aged 3 and over had a main language other than English. In 2011, English was not the main language of 3.1 per cent (54,500 people). 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). The statistics released in the 2021 Census show an increasingly diverse population across ethnic group, main language, country of birth and passports held. This increasing diversity is evident to a greater or lesser degree across all 11 local councils

	https://www.nisra.gov.uk/system/files/statistics/census-2021-main-statistics-for-northern-ireland-phase-1-statistical-bulletin-ethnic-group.pdf PHA Workforce (Sept 2024) • Not assigned 91.98% • White 8.02%
Sexual Orientation	The NI Census collected information on sexual orientation for the first time in 2021. NI population (Census 2021) highlighted: • 31,600 people aged 16 and over (or 2.1%) identified as LGB+ ('lesbian, gay, bisexual or other sexual orientation'), • 1.364 million people (90.0%) identified as 'straight or heterosexual' • 119,000 people (7.9%) either did not answer the question or ticked 'prefer not to say'. • 4.1% of adults (1 in 25) in Belfast identified as LGB+, while 1.1% of adults in Mid Ulster identified as LGB+. • 4.6% of people aged 16 to 24 identified as LGB+, this falls to 0.3% of people aged 65 and over. • Across England, Wales and Northern Ireland, Northern Ireland (2.1%) has the lowest percentage of people who identify as (LGB+), thereafter comes Wales with 3.0% of people who identify as LGB+ and then England with 3.2% (Census 2021) <u>PHA Workforce (Sept 2024)</u> • Do not wish to answer 0.50% • Not assigned 94.19% • Opposite sex 4.71% • Both Sexes Same sex 0.60% All statistics pertaining to PHA workforce were provided through Human Resources Equality monitoring information in Sept 2024

2.3 Qualitative Data

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

The PHA Partnership and Engagement Strategy (2025-2030) covers a wide range of issues across the three domains of Public Health - Health Improvement, Health Protection, Safety and Quality. There is also close relationship with Research and Development with an aim of embedding experience and involvement into the areas of work which seeks to improve the health and wellbeing of all people in NI (covering all section 75 groups) as well as reducing health inequalities.

The document is high level and sets the strategic direction, and will be supported by an action plan and associated workplans for each programme area. There will also be qualitative data garnered through the monitoring framework for Partnership and Engagement working which includes PHA and the wider HSC. The strategy also recognises organisational reorganisation and the need to support staff, especially at a time of reform to prioritise Experience and Involvement as part of their everyday working.

In line with the wider PHA Corporate plan, the health and well-being of individuals and groups spans a wide range of issues throughout their lives. The Agency recognises that the needs, experiences and priorities of individuals and groups within each Section 75 category may vary substantially. Some overarching work has been conducted over recent years to identify emerging themes regarding these, documented in publications such as;

- the PHA's "Health Briefings" www.publichealth.hscni.net/directorate-operations/communication-and-knowledge-management/health-intelligence

- the HSC document on “Section 75 Groups - Emerging Themes” (ECNI - Equality Commission for Northern Ireland)

- DoH, Social Services and Public Safety publication on inequalities monitoring (Equality Screenings 2018 to 2024 - Business Services Organisation (BSO) Website)

No one screening exercise or EQIA can do justice in consideration to all aspects as detailed below and will be informed by the outworking of the strategy

Category	***Needs and Experiences***
Gender	
Age	
Religion	
Political Opinion	
Marital Status	
Dependent Status	
Disability	
Ethnicity	
Sexual Orientation	

PHA recognises that the needs, experiences and priorities of individuals and groups within each Section 75 category will vary and that some may require specific needs to experience the positive impact on health inequalities intended in this strategy. As PHA takes forward work to achieve each outcome, the actions, work and programmes will be screened individually. It is at this more detailed level that the needs, experiences and priorities of and potential impact on the Section 75 named groups will be considered and assessed specifically to enable meaningful involvement and recognition through the outworking of the Partnership and Engagement Strategy for PHA

The direction set out in the strategy is closely aligned with the core functions of the Agency, as defined by the legislation (DoH Circulars 2007, 2009, 2012) , and with other key strategies including the Making Life Better Public Health Framework and draft PFG.

(https://engage.hscni.net/about/strategic-involvement-policy-2/)

2.4 Multiple Identities

Are there any potential impacts of the policy or decision on people with multiple identities? For example; disabled minority ethnic people; disabled women; young Protestant men; and young lesbians, gay and bisexual people.

It is possible that some of the work taken forward under the outcomes set out in the Partnership and Engagement Strategy may impact on people with multiple identities. PHA recognises that the needs and experiences of people with multiple identities will vary across our work. In our commitment to ensuring that potential impacts are considered and mitigated, PHA will screen policies and strategies individually to ensure that the potential impacts of each policy or strategy are considered fully in that context.

2.5 Making Changes

Based on the equality issues you identified in 2.2 and 2.3, what changes did you make or do you intend to make in relation to the policy or decision in order to promote equality of opportunity?

In developing the policy or decision what did you do or change to address the equality issues you identified?	***What do you intend to do in future to address the equality issues you identified?***
The development of the Partnership and Engagement Strategy included ensuring that it fully reflected the PHA role in experience and involvement through the lens of Health Inequalities and Inclusion Health areas of work. Commitments within the strategies explicitly aim to address key equality issues. In partnership with the PHA Communication team the P&E Strategy has been screened for accessibility and translated into Plain English. Therefore it is written in a style to make it accessible and understandable for a wide range of external stakeholders as well as PHA staff. When preparing the Strategy, we took the opportunity to review the purpose, vision and values for Experience and	The P&E Strategy will be reviewed by stakeholders through a period of public consultation with a focus on possible equality issues and time has been allocated to make amendments to alleviate any issues. The planned consultation offers opportunity to meet with C&V partners specific to Health Inequalities and the approach will be adapted to support meaningful engagement and discussion of the strategy. The views gathered will inform the final published strategy, The strategy will also be translated into Easy Read format and for Children and Young People to support their input into the process. The strategy will be published on the Engage Website which is supported

Involvement with key stakeholders to ensure its continued relevance to our work and our population.	through the Read Deck and browser support for translation into other languages.

2.6 Good Relations

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

Group	***Impact***	***Suggestions***
Religion	Tackling the major inequalities in health and wellbeing and their causes will help promote equality of opportunity and good relations.	Continued focus on Partnership working and public participation at regional, local and community level
Political Opinion		
Ethnicity		

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

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

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

Please tick:

Major impact	
Minor impact	
No further impact	/

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

Please tick:

Yes	
No	/

Please give reasons for your decisions.

The P&E Strategy outlines the strategic direction for the PHA in regards to partnership working and also for the work of the PHA's newly formed Partnership and Engagement team. Both the Experience and Involvement programmes of work contained within the P&E Strategy, have a focus on ensuring that the culture and practice of the PHA, across its range of responsibilities is mindful of and supports meaningful engagement with those for whom services are designed, developed and delivered.

The Strategy sets out the direction for the PHA from 2025-2030 in regards to how partnership working is progressed both from a regional leadership perspective and also from an organisational perspective internally.

The P&E Strategy supports the PHA's commitment to tackling health and wellbeing inequalities and brings a focus to the concept of Inclusion Health.

The Strategy through the explicit commitment to Partnership working, aims to ensure that meaningful collaboration with and engagement of service users, their families and carers, and all communities, means that such an approach, is systemic throughout the PHA and reflected in our leadership role across the HSC. The programme of work set down through the Strategy directly supports, enhances and complements the Section 75 Agenda, whilst promoting a shift across the health service, to work in partnership with the all communities across the population of Northern Ireland.

PHA does recognise however, that the needs, experiences and priorities of groups within each Section 75 category may vary substantially and specific needs may need addressed to ensure that all people can experience the intended positive impact of the Partnership and Engagement Strategy. This will be reflected in equality screening across defined areas of work as they progress.

(4) CONSIDERATION OF DISABILITY DUTIES

4.1 In what ways does the policy or decision encourage disabled people to participate in public life and what else could you do to do so?

How does the policy or decision currently encourage disabled people to participate in public life?	***What else could you do to encourage disabled people to participate in public life?***
The P&E strategy is an inclusive strategy. At the heart of the work of Experience and Involvement is a commitment to ensuring that any member of the public who wish to share their experience or get involved in shaping the HSC, has the opportunity to do so, this includes people with disabilities. This is included as a commitment within the 5 year strategy. Reach outs are planned with a range of advocacy groups to secure input from those with disabilities both to the development of the P&E Strategy itself and also to ongoing work that the P&E Team in the PHA will either be leading on or involved with.	Reach our more pro-actively to encourage more disabled people to get involved in HSC based service user / carer groups. As part of the good practice guidance that we develop and share in the HSC, we will look to co-design more of these with disabled people and their advocates, aiming to identify and address barriers to their participation. Ensure that we make our partners aware of the need to comply with the Re-imbursement of Out of Pocket Expenses policy, which should support people to be able to participate in partnerships and wider engagement with the PHA & wider HSC

4.2 In what ways does the policy or decision promote positive attitudes towards disabled people and what else could you do to do so?

How does the policy or decision currently promote positive attitudes towards disabled people?	***What else could you do to promote positive attitudes towards disabled people?***
The P&E strategy is an inclusive strategy and at the heart of the work of Experience and Involvement, is ensuring that any member of the public who wish to share their experience or get involved in shaping	We could (with the agreement of the individuals involved) highlight the contributions that disabled people have made to the work of the HSC through partnerships that they have been engaged in.

the HSC has the opportunity to do so, this includes people with disabilities. The PHA actively promotes the inclusion of disabled people in service planning, monitoring and evaluation through Personal and Public Involvement initiatives and advisory groups. The PHA has additional regional leadership responsibilities for PPI as detailed in the strategy. These include • The implementation of PPI across the HSC • The chairing of the regional HSC PPI forum • Report sharing best PPI practice across all HSC bodies • The establishment and pilot of robust PPI monitoring arrangements • Raising awareness of and understanding PPI through training	Encourage positive attitudes to disabled people and challenge negative stereotyping through availability of corporate training programs such as e-learning Discovering Diversity programme, Public Health eLearning module.

(5) CONSIDERATION OF HUMAN RIGHTS

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

ARTICLE	Yes/No
Article 2 – Right to life	No
Article 3 – Right to freedom from torture, inhuman or degrading treatment or punishment	No
Article 4 – Right to freedom from slavery, servitude & forced or compulsory labour	No
Article 5 – Right to liberty & security of person	No
Article 6 – Right to a fair & public trial within a reasonable time	No
Article 7 – Right to freedom from retrospective criminal law & no punishment without law	No
Article 8 – Right to respect for private & family life, home and correspondence.	No
Article 9 – Right to freedom of thought, conscience & religion	No
Article 10 – Right to freedom of expression	No
Article 11 – Right to freedom of assembly & association	No
Article 12 – Right to marry & found a family	No
Article 14 – Prohibition of discrimination in the enjoyment of the convention rights	No
1st protocol Article 1 – Right to a peaceful enjoyment of possessions & protection of property	No
1st protocol Article 2 – Right of access to education	No

If you have answered no to all of the above please move on to ***Question 6*** *on monitoring*

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

List the Article Number	Interfered with? Yes/No	What is the interference and who does it impact upon?	Does this raise legal issues?* Yes/No

** It is important to speak to your line manager on this and if necessary seek legal opinion to clarify this*

5.3 Outline any actions which could be taken to promote or raise awareness of human rights or to ensure compliance with the legislation in relation to the policy or decision.

(6) MONITORING

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

Equality & Good Relations	Disability Duties	Human Rights
A range of information and data will be collected, including through the consultation period, to help us fulfil our legal requirements as well as assist in the planning of future developments for Partnership and Engagement. This includes data gathered through: • Involvement monitoring returns. • Training. • Specific Experience projects through mechanisms such as 10,000 MORE Voices • Information from contracted companies such as Care Opinion • Attendance at service user forums/workshops	A range of information and data will be collected, including through the consultation period, to help us fulfil our legal requirements as well as assist in the planning of future developments for Partnership and Engagement. This includes data gathered through: •Involvement monitoring returns. •Training. •Specific Experience projects through mechanisms such as 10,000 MORE Voices •Information from contracted companies such as Care Opinion •Attendance at service user forums/workshops	Data on promoting a culture of respect for human rights within the PHA. For example, reflected in the PPI standards and ethical practices within Involvement in R&D

A range of information and data, including inclusion and participation of disabled people where possible, will be collected to help us fulfil our legal requirements as well as assist in the planning of services for the future

Approved Lead Officer: Martin Quinn

Position: Assistant Director for Partnership and Engagement

Date: 07/08/2025

Policy/Decision Screened by:

Business Unit and contact details

Please note that having completed the screening you are required by statute to publish the completed screening template, as per your organisation’s equality scheme. If a consultee, including the Equality Commission, raises a concern about a screening decision based on supporting evidence, you will need to review the screening decision.

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

Template updated January 2015

Any request for this document in another format or language will be considered. Please contact us (see contact details provided above).