The Regulation and Quality Improvement Authority

Baseline Assessment of Access to Services for Disadvantaged Groups in Northern Ireland: Scoping paper

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Assurance, Challenge and Improvement in Health and Social Care

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Contents

1. Introduction

Good access to health and social care services has long been recognised as fundamental to people's health and wellbeing. Accessible health care relates to a number of factors including availability, addressing cultural and linguistic barriers and being able to communicate effectively. It is important to have a prompt diagnosis and subsequent treatment. It is also important to be able to obtain quality preventive care early enough to avoid illness or complications

Tackling inequalities in health and social care is a key element of A healthier Future: A Twenty Year Vision for Health and Wellbeing in Northern Ireland 2005-2025. The strategy highlights the links between deprivation and ill health, and the need to tackle the social, economic and environmental inequalities that impact on health and wellbeing. It also highlights that there has to be a focus on narrowing the health gap between disadvantaged groups and the rest of the country.

Following a consultation process, access to services by disadvantaged groups was identified as an area to be included in the 2012- 2015 RQIA review programme. The focus of the review was to examine the accessibility and arrangements in place for the delivery of health and social care for disadvantaged groups in Northern Ireland.

It became clear that there were a number of difficulties involved in taking forward the review in its original format.

1.1 Definition of a Disadvantaged Group

Within the literature there is no currently agreed definition of a disadvantaged group and this term is not readily used by for e.g. the Northern Ireland Equality Commission within equality legislation. It is often used as a generic term for those "from lower-income backgrounds". In relation to a specific groups such as travellers for example, this community has suffered disadvantage and discrimination in all fields of life[1]

Social disadvantage can be defined in relation to socio-economic aspects (including income, employment, education and socioeconomic status) as well as socio-cultural aspects (such as gender, ethnicity, religion, culture, migrant status, and social capital), and socio-geographic aspects (such as living in a deprived neighbourhood) and age[2].

People see themselves as disadvantaged to the extent they are denied access to, and use of the same tools found useful by the majority of society. These include autonomy, incentive, responsibility, self-respect, community support, health, education, information, employment, capital, and responsive support systems

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[1] Council of Europe 2009

[2] World Health Organisation

A major feature of disadvantaged groups is the presence of barriers to self-sufficiency and a disadvantaged group may be defined by the particular pattern of denied resources and barriers it faces. Each group will present its own pattern of disadvantage and the implied solutions vary from group to group. There are a number of barriers to self-sufficiency which will lead to a group considering themselves to be disadvantaged.

- Unavailability of resources. Resources (employment, capital etc.) may be unavailable in sufficient quantity to certain groups; opportunities might also be limited.
- Inaccessibility of resources. If available, resources may be still be inaccessible to certain groups because of cost, poor design, locale or distance or lack of appropriate publicity.
- Society's regard for a group. Disadvantaged groups are often unappreciated or derided by the larger society. If a group is seen as not being able to offer much, little is offered to it.
- Government practices. There may be too few programmes/improvement initiatives available or they may be underfunded or otherwise inadequate.
- Conditions of the group. Certain features of the disadvantaged group itself may make it hard to access the necessary tools. For example to use resources offered by society may mean contradicting their own values or culture[3].

1.2 Access to Services

The other main difficulty which arose was in terms of what is meant by access to services, and against which services was access to be measured. Access is seen to be a complex concept.

- If services are available, and there is an adequate supply of services, then the opportunity to obtain healthcare exists, and a population or group may have access to services.
- The extent to which a population gains access also depends on financial, organisational and social or cultural barriers that limit the utilisation of the services. Thus access measured in terms of utilisation is dependent on the affordability, physical accessibility and acceptability of services and not merely adequacy of supply.
- Available services must then be relevant and effective if the population/group is to gain access to satisfactory health outcomes.
- The availability of services and barriers to access have to be considered in the context of the differing perspectives, health needs and material and cultural settings of diverse groups in society[4].

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[3] What is a "Disadvantaged Group? Steven E. Mayer, Ph.D. Effective Communities Project Minneapolis Revised November 2003.

[4] Guilford M et al. J Health Serv Res Policy. 2002 Jul;7(3); 186-188

It can be concluded that many groups in terms of the above information will see themselves as being disadvantaged. Access to healthcare is very difficult to define and quantify and will again depend very much on the group that is being assessed.

In light of these difficulties, a decision was taken to limit the review to development of a position paper in relation to access to health services for a number of defined groups that may be considered to be disadvantaged. A recommendation(s) would then be made as to any further work review work that needed to be carried out in this area.

This paper has been developed to provide initial scoping in relation to access to services for four disadvantaged groups within HSC services in Northern Ireland in relation to the RQIA programme for 2012-15. The four disadvantaged groups identified are:

- travellers
- homeless people
- lesbian, gay, bisexual and transgender (LGB&T) people
- black minority ethnic (BME) people.

2.0 Methodology

- A literature review was carried out to try to provide information as to the number of people in each of these groups and some of the problems they may meet in terms of access to health services.

- Meetings were held with HSC staff including equality leads, personal and public involvement (PPI) representatives, leads in public health, health improvement and health promotion within HSC trusts and the Public Health Agency in order to ascertain what services were available and what initiatives had been undertaken for these groups.

- Meetings were also held with voluntary organisations representing the interests of the four groups.

3.0 Findings

3.1 Proportion of People in Disadvantaged Groups

Homelessness

Homelessness has been increasing since the early nineties[5]. Between 2005/06 and 2009/10 the numbers levelled off only to see a significant increase in 2010/11 when 20,158 households presented as homeless. 6,122 families presented as homeless during the year 2009/10. This is an increase of 7 per cent on that recorded in 2004/05 (5,700). Using the 2009/10 homelessness statistics the percentage of households accepted as homeless in Northern Ireland is 1.47 per cent of all households which is similar to Scotland (1.56 per cent) but significantly greater than England and Wales (0.19 per cent and 0.45 per cent respectively).

Black Minority Ethnic (BME) Groups

On Census Day 2011, 1.8 per cent (32,400) of the resident population of Northern Ireland belonged to minority ethnic groups, more than double the proportion in 2001 (0.8 per cent).

From the census figures the main minority ethnic groups are Chinese people (6,300), Indian (6,200), Mixed (6,000) and Other Asian (5,000), each accounting for around 0.3 per cent of the resident population. Black Africans accounted for 2,345 people in 2011 which is 0.1 per cent of the population. Belfast (3.6 per cent), Castlereagh (2.9 per cent), Dungannon (2.5 per cent) and Craigavon (2.1 per cent) have the highest proportions of residents from minority ethnic groups.

Travellers

Irish Travellers account for 1,300 people comprising 0.1 per cent of the population. Compared with 2001, increases were recorded for all minority ethnic groups with the exception of Irish Travellers whose numbers fell from 1,700 in 2001 to 1,300 in 2011.

The largest proportion of travellers in Northern Ireland, (22 per cent) resides in the Belfast area, followed by Dungannon (17 per cent), Craigavon (12 per cent) and Londonderry (11 per cent).

Lesbian Gay, Bi-sexual and Transgender

Almost three-quarters of a million UK adults say they are gay, lesbian or bisexual - equivalent to 1.5 per cent of the population[6]. The Office for National Statistics (ONS) has indicated that 480,000 (1 per cent) consider themselves gay or lesbian, and 245,000 (0.5 per cent) bisexual. London has

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[5] Homelessness Strategy for Northern Ireland 2012-2017. Housing Executive

[6] Office for National Statistics (ONS)

the highest percentage of those polled identified as gay, Lesbian or bisexual and Northern Ireland has the lowest.

Currently there is no validated estimate of the number of trans persons living in Northern Ireland as this information is not collected in the census data. The difficulties in estimating the proportion of Lesbian, Gay, Bisexual and Transgender (LGB&T) individuals in a population are recognised. It is only in recent years with the emergence of equality and human rights legislation that there has been a substantive research focus on the lives of LGB&T people in Northern Ireland. Although the acronym is used as an umbrella term, and the health needs of this community are often grouped together, each of the groups represented by the acronym is a distinct population with its own health concerns. Draft guidelines are currently in the process of being drawn up for use in health and social care environments, and it is expected that these will be launched in 2014. This process has involved representation from RQIA.

4.0 Strategic Overview

People who can be considered as belonging to a marginalised or disadvantaged group experience social inequalities that can impact on their health and wellbeing, and so cause health inequalities. Avoidable health inequalities arise because of the circumstances in which people grow, live, work and age and the systems put in place to deal with illness[7].

The Marmot Review into health inequalities in England demonstrated that many of the examples of premature death or illness are preventable. It presented a substantial body of evidence locally, regionally and globally regarding health inequalities, including evidence of effective interventions, which reinforces the argument that addressing this issue requires co-ordinated action across the social determinants of health.

It also suggested that health inequalities are preventable and unjust differences in health status are experienced by certain population groups. People in lower socio-economic groups are more likely to experience chronic ill-health and die earlier than those who are more advantaged. Health inequalities are not only apparent between people of different socio-economic groups - they exist between different genders and different ethnic groups[8].

There are a number of strategic documents that highlight the importance of good health and access to services, regardless of the social group that people belong to.

4.1 Investing for Health Strategy 2002

The strategy contains a framework for action that is based on multi-sectoral partnership working between departments, public bodies, local communities, voluntary bodies, district councils and social partners. Within the Investing for Health Strategy[9] in Northern Ireland the following values are underpinned:

- Health is a fundamental human right.
- Policies should actively pursue equality of opportunity and promote social inclusion.
- Individuals and communities should be fully involved in decision making on matters relating to health.
- All citizens should have equal rights to health, and fair/equitable access to health and health information according to their needs.

The key aims of the strategy are to improve life expectancy across the population and to reduce health inequalities.

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[7] Commission on the Social Determinants of Health (CSDH)

[8] Marmot Review: “Fair Society, Healthy Lives” – A Strategic Review of Health Inequalities in England “2010.

[9] The Northern Ireland public health strategy ‘Investing for Health. 2002 Department of Health, Social Services and Public Safety.

4.2 A Healthier Future: A twenty Year Vision for Health and Wellbeing in Northern Ireland 2005-2015.

This strategy notes that engagement with everyone is a necessary pre-requisite for the development of responsive HSC services. However, people from a range of groups find it difficult to engage with services, and steps need to be taken to ensure that everyone has an opportunity to be heard, and that services are accessible to all.

The strategy outlines that there are many reasons why some groups have difficulty in engaging with services. It may be due to social exclusion, communication barriers or they may be in some way stigmatised by society. Groups who will need particular focus in the future include:

- people with disabilities
- carers
- some children and young people
- travellers
- black, ethnic and minority communities
- people with mental health problems
- asylum seekers and refugees
- people with alcohol and drug dependency problems
- gay, lesbian ,bisexual and transgender people
- older people
- homeless people
- victims

4.3 Investing for Health Strategy 2010
Social Gradient

In considering inequalities in health, there is a well-established relationship between a person's social background and their health outcomes. Those from a disadvantaged background are more likely to suffer ill health and die younger than their counterparts from less disadvantaged backgrounds. However, the relationship between health and social circumstances is graded: the lower a person's social position, the worse his or her health is[10]. A more recent public health strategic document[11], takes account of the conclusions of Investing for Health 2010. This Strategy refers to the "health gap" where people in different social circumstances experience avoidable differences in health, wellbeing and length of life, i.e. inequalities in health, which arise because of inequalities in society. The strategy has stated that in the last ten years there has not been a noticeable narrowing of this gap in Northern Ireland. (p15). In relation to the gap in life expectancy, males living in the 10 per cent least deprived areas in Northern Ireland could expect on average to

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[10] Investing for Health Strategy, (2010) DHSSPS

[11] Fit and Well Changing Lives – 2012-2022. DHSSPS Public Health Strategy

live almost 12 years longer than their counterparts living in the 10 per cent most deprived areas. For females, the gap is more than eight years.

4.4 Transforming Your Care 2011

‘Transforming Your Care: A Review of Health and Social Care in Northern Ireland’ (2011)[12] highlights the need to review ways of working to ensure that there is a client centred approach to meeting key health care needs, particularly for marginalised or disadvantaged groups in society. Within the scope of TYC it has been highlighted as an objective that there is a statutory duty on the HSC to improve the quality of services provided, to improve the health and social wellbeing of the population and to reduce health inequalities. As previously indicated within the Marmot review people in lower socio-economic groups are more likely to experience chronic ill-health and die earlier than those who are more advantaged. Therefore, those who live in the 20 per cent most deprived areas are 40 per cent more likely to die before the age of 75. Some of the most common characteristics associated with being born into poverty rather than more affluent circumstances have been listed as the following[13]:

- lower life expectancy
- 23 per cent higher rates of emergency admission to hospital
- 66 per cent higher rates of respiratory mortality
- 65 per cent higher rates of lung cancer
- 73 per cent higher rates of suicide

Transforming Your Care (TYC) has reported that Health and Social Care alone cannot fully address the inequalities issue and that it is import for there to be good partnership arrangements with other statutory bodies such as housing, education, environment as well as with local communities. But, there is an obligation on health and social care bodies to identify change and how it can contribute to better outcomes for people. The report highlights that services should support people to take good decisions about their health and wellbeing, with a particular focus on the needs of those groups that typically have poorest health outcomes. Services need to be much better integrated to improve the quality of experience for patients and clients and also improve safety and outcomes. This requires making it easier for people to use the system and for clinicians to organise care around the individual, with better communication and networking across primary, secondary and tertiary care. (p40).

In a response from Belfast Healthy Cities (BHC) to the Transforming Your Care consultation: Vision to Action it is stated that “We want to see better health and equal well-being for all, as an equal human right. Money does not buy better health. Good policies that promote equity have a better chance”. BHC has emphasised that it is essential that in the implementation of TYC,

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[12] Transforming Your Care. (TYC) DHSSPS 2011. Final document

[13] CF: TYC. NISRA Inequalities Monitoring Report 2010

consideration is given to “equity of access”. From a WHO perspective this includes: equity of treatment, equity of outcome and equity of cost.

5.0 Legal Position

To be eligible for full access to free treatment a person needs to be living in Northern Ireland. The technical term for living here is being "ordinarily resident" and includes all asylum seekers, refugees, migrant workers, resident family members, most students (except those on short courses), and other persons who are settled in the UK[14].

5.1 Equality Legislation
Public Sector Duties

Public sector bodies are required to produce equality schemes approved by the Equality Commission for Northern Ireland (ECNI) and to carry out equality impact assessments on the basis of a template developed by the Commission.

In April 2010 ECNI published new guidance for public authorities on the implementation of Section 75 of the Northern Ireland Act 1998.
The guidance included a recommendation that:-

> "…. public authorities include within their equality scheme a commitment to develop action measures/action plans which detail how they will undertake the promotion of equality of opportunity for the nine equality categories and good relations for the three good relations categories."

As part of the process of developing an action plan the guidance recommended that public authorities should:

- undertake an audit of inequalities to identify the range of key inequalities which the discharge of the public authority's functions is intended to or is likely to address.
- develop action measures based on functions and key inequalities identified;"

and that these need to be "flexible, adaptable and responsive to changing circumstances and needs".

Equality Sections

Under Section 75 of this Act, public authorities are required to have due regard to the need to promote equality of opportunity relating to the following:

- 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

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[14] Policy Briefing. Law Centre (NI). June 2013.

- between persons with dependents and persons without
- public authorities are also required to have regard to the desirability of promoting good relations between persons of different religious belief, political opinion or racial group

Good Relations Requirement Under Equality Legislation

Section 75 (2)[15] places a legal requirement on the public sector in Northern Ireland to put good relations at the heart of public policy and its implementation, and to shape policies around the people they affect. This statutory duty means a public authority must consider how the policies it makes and implements affect relationships amongst the people it serves and employs. There is therefore a clear duty under Section 75 on public authorities to address both equality of opportunity *and* good relations.

5.2 Human Rights

Public authorities are also bound by human rights standards in both international and national law to take a human rights based approach. A rights based approach incorporates equality, participation, transparency, and accountability, paying specific attention to the most vulnerable in society. Many aspects of a rights based approach can be found in equality and good relations duties. Public authorities must also build equality and good relations into everything and these should feature in business plans and all other strategies.

5.3 Ethnic Monitoring

The Race Equality Strategy 2005-2010[16] identified ethnic monitoring as an essential action in order to achieve racial equality. Ethnic monitoring allows service providers to identify possible inequalities and investigate the causes and address any unfairness or disadvantage. However, monitoring is also an important strand in ensuring that public authorities meet their statutory and international obligations, such as those arising from Section 75 of the Northern Ireland Act 1998, the Race Relations Order (NI) 1997 and the UN Convention on the Elimination of Racial Discrimination.

In July 2011, the Office of the First Minister and Deputy First Minister (OFMDFM) published “Guidance for Monitoring Racial Equality[17]” which provided a standardised framework to help public bodies collect information in a consistent but flexible manner. The adoption of the framework would enable the benchmarking of monitoring data with the 2011 Census of Population

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[15] Promoting Good Relations. A Guide for Public Authorities.Section 75 of the Northern Ireland Act 1998. A Guide for Public Authorities. Equality Commission for Northern Ireland.

[16] A Racial Equality Strategy for Northern Ireland. 2005 – 2010. Office of the First Minister and Deputy First Minister

[17] Guidance For Monitoring Racial Equality**.** Office of the First Minister and Deputy First Minister. July 2011

results in a standardised manner. The Health & Social Care Board has led on a project to improve ethnic monitoring within Health and Social Care systems.

The following areas are involved:

- child health system
- community systems -
  - social services client administration and retrieval environment,
  - regional sure start database;
- hospital systems –
  - patient administration system - inpatients,
  - A&E systems
  - Northern Ireland maternity system.

Ethnic monitoring went live on the above areas during 2013/2014, subject to the satisfactory completion of system changes, delivery of staff training and the production of information leaflets for the public. After a period of 12-18 months the systems will be evaluated to determine their effectiveness. The collecting of this data will cover groups relating to section 75. However, there is no information that will be collected using this method that will capture information on use of services by homeless people.

From a disadvantaged group's perspective, public authorities should be looking for things like unusually large (or small) numbers of people from particular groups reporting problems. They should also check that people from disadvantaged groups are satisfied with the services they receive and that appropriate services are being provided in terms of language or cultural needs.

5.4 Equality Legislation – HSC Trust Audits

In order to ensure that all HSC Trusts are encompassing Section 75 requirements within their work streams, they were asked to complete an audit to address emerging themes in relation to key inequalities experienced by the nine Section 75 equality categories. In the course of conducting the inequalities audit, it became evident that there were a number of recurrent cross cutting themes. These were:

- measures to improve access to services
- communication and information
- service monitoring
- measures to promote, participation and inclusion
- service specific, procurement and employment related issues

These cross cutting themes have influenced the format and content of the trusts' action based plans. The trusts identify key actions that can be taken forward regionally to provide consistency of approach and avoid duplication of work. Each of the trusts has identified local actions that relate directly to the inequalities identified in their own trust area.

All trusts have produced equality action plans, which are regularly monitored and which are submitted to the Equality Commission. As part of this process the trusts submit annual progress reports to the Equality Commission on the implementation of their equality scheme.

The trust actions plans seek to bring about real and tangible outcomes for service users and staff as per the Equality Commission guidance, in order to make a shift from process to outcomes.

5.5 DHSSPS Equality Action Plan for the Department of Health, Social Services and Public Safety (Version 1.1 April 2012)[18].

Within the Equality Action Plan for the Department of Health, Social Services and Public Safety (Version 1.1 April 2012) a number of actions relating to disadvantaged groups were identified which included:

- raising awareness of migrant workers' entitlement to services and lack of clarity on the rights and entitlements of the different categories of migrant workers
- Some marginalised women (with disabilities, traveller women and BME women younger women, rural women etc.) have difficulty in accessing maternity services. Maternal and infant mortality rates are higher among Black and Minority Ethnic (BME) groups. BME women were more likely to access services late e.g. not have a scan by 20 weeks, attend antenatal classes, have a post natal check-up and were more likely to experience complications. These issues have been addressed through a review of maternity services, with consideration given to current service provision at each stage of pregnancy.

5.6 DHSSPS Section 75 Annual Progress Report 2012 – 2013[19]

Tackling health inequalities has remained a priority for the DHSSPS, and is one of the key drivers for many of its strategies and policies. The DHSSPS published and consulted on Fit and Well – Changing Lives a new cross cutting public health strategy to replace Investing for Health. The DHSSPS maintains an extensive system to monitor health inequalities in Northern Ireland - the Northern Ireland Health and Social Care Inequalities System (NIHSCIMS). This comprises indicators which are monitored over time, to assess area differences in mortality, morbidity and utilisation of and access to health and social care services in Northern Ireland.

In October 2011, a Hard to Reach Domestic and Sexual Violence Working Group was established in to help deliver on relevant actions in the Strategy's

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[18] http://www.dhsspsni.gov.uk/equality_action_plan_april_2012_pdf..pdf

[19] Public Authority 2012 – 2013 Annual Progress Report on: Section 75 of the NI Act 1998 and Section 49A of the Disability Discrimination Order (DDO) 2006 Department of Health, Social Services and Public Safety Strategic Management Branch.

Action Plan. Its function was to better engage hard to reach groups, including LGBT, older people, ethnic minorities and people with disabilities, ensuring that the unique needs of these people are met. Membership of the group included stakeholders from a broad range of organisations which represent the interests of individuals from hard to reach groups.

6.0 Access to Healthcare for Disadvantaged Groups

Appropriate access to health care for a diverse population requires more than simply providing the service. HSC Trusts in Northern Ireland have undertaken much work in providing and promoting good access to healthcare for everyone. However, as previously indicated, good access to healthcare is dependent on a wide range of factors and those who live in disadvantaged areas or who come from disadvantaged groups can be more susceptible to how healthcare is delivered.

The 2009/10 GP patient survey (Ipsos MORI, 2010) reported that, overall, non-white patients were less positive about their experience of the GP surgery than white patients.

In the WHSCT area, over half (57 per cent) of respondents were satisfied with the health service, while 1 in 10 were dissatisfied. Migrants were more positive about the care they received in hospital than at their GP surgery (Jarman, 2009). In relation to the UK‟s GP-as-gatekeeper system, those from countries with direct access to medical specialists were unconvinced by GP's competence and frustrated by the referral process (Bell et al., 2009a)[20].

6.1 Homeless People

A number of measures have been put in place to help make access easier for disadvantaged groups. Some groups are more homogenous which can make it easier to identify barriers to them being able to access health care, e.g. addressing language or cultural issues. However, homeless people are a much more diverse group.

Homelessness is a situation that occurs as a result of life circumstances. This can be through losing a job, a relationship breakdown, mental health problems and/or drug addiction/alcohol dependency. Homelessness presents a considerable risk to both mental and physical health and people in this situation have a significant number of complex needs. Often there is a combination of factors which puts them at an even greater health risk than other disadvantaged groups. They also then experience a much poorer quality of life compared to other disadvantaged groups. Continued homelessness can lead to a downward spiral for the person that makes it more difficult for them to access mainstream health care services and they can become even more isolated and marginalised from the rest of society. As a result, when homeless people do come to the attention of healthcare services, it is often when their health is in a very poor state, which then requires even more intensive support and care. Often due to insecure accommodation, homeless people are not registered with a GP and are much

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[20] Health Intelligence briefing. Minority ethnic groups. PHA. Jan 2012

less likely to access any preventative care e.g. health screening. This makes them more susceptible to illness and infection which may otherwise have been addressed at an earlier stage.

Unlike other disadvantaged groups, there is also no specific reference to homeless people within section 75 of the equality legislation.

The Northern Ireland Human Rights Commission showed that people excluded from assistance and welfare benefits as a result of being homeless, were more vulnerable to various forms of exploitation, ill health and disability. The same report found that a number of people with no recourse to public funds became homeless because of ill health or disability, and in a number of cases people became ill as a result of their destitution[21].

In a study by the DOH in England[22] it was found that the average length of stay for homeless people in hospital was 6.2 days, compared to 2.1 days for the general population. The DoH stated that all acute hospitals should have admission and discharge policies ensuring homeless people are identified on admission, and linked into services on discharge. However it was found that only a quarter of clients admitted to hospital were given help with their housing before they were discharged.

6.2 Travellers

Gypsies and travellers have been considered to be the most disadvantaged minority within our society and they are officially recognised as an ethnic group. Infant mortality and mental health rates are higher, and life expectancy significantly lower (10-12 years lower) in the gypsy - traveller community. Travellers face major difficulties in accessing healthcare. The reluctance of some GPs to register gypsy and traveller families has been as a result of a perception that they are demanding patients who miss appointments and don't comply with treatment plans[23].

Similar challenges for travellers in terms of premature mortality have been found in Northern Ireland as in the Republic of Ireland (ROI). travellers die about 15 years earlier than the general population in Northern Ireland. Only 1 in 10 of the traveller population is over 40 years of age and 1 in 100 is over 65[24]. Child mortality up to the age of 10 has been found to be 10 times that of the population as a whole. Infant mortality has regularly been considered a good indicator of a population's level of health and development. Looking at the gap between the traveller and general population in terms of a relative difference the situation has deteriorated since 1987. Traveller infants today are 3.6 times more likely to die than infants in the general population. In 1987

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[21] Human Rights Commission. Devlin, R. (2009)

[22] Healthcare for single homeless people DoH, 2010

[23] Cooperation and Working Together (CAWT) literature review on health concerns of travellers and their access to healthcare provision.

[24] Investing for Health. DHSSPS. 2002.

when rates were much higher in both groups, traveller infants were 2.4 times more likely to die than infants in the general population.[25]

NI/RoI Traveller Health Survey 2010

- Most traveller respondents felt their opportunities to access services were about the same as everyone else.
- 72.3 per cent in ROI and 73.5 per cent in NI thought their access to the A & E was the same, with 14.9 per cent in ROI and 17.9 per cent in NI rating their access as worse, and 12.8 per cent in ROI and 8.6 per cent in NI as better, than everyone else.

Respondents were asked to rate various difficulties in accessing health services. The barriers identified included:

- The waiting list (cited by 62.7 per cent of respondents in ROI and 46.8 per cent in NI).
- Embarrassment (47.8 per cent in ROI and 50.0 per cent in NI).
- Lack of information (37.3 per cent in ROI and 28.6 per cent in NI).

As the SHSCT area includes the Co-operation and Working Together (CAWT)[26] region, CAWT produced literature reviews around key issues regarding access to services for travellers and LGB&T people. A number of areas identified as barriers to services included staff attitudes; language, Literature and Signage & Way finding[27] .Barriers identified regarding access to services for travellers were seen to be in relation to the following:[28]

- a lack of cultural awareness and acceptance amongst healthcare professionals
- negative stereotypes
- embarrassment
- poor communication

6.3 Lesbian, Gay, Bisexual and Transgender (LGB&T)

A number of reviews have indicated that LGB&Ts experience significant barriers to accessing health services and often service providers assume their needs are similar to those of heterosexual men and women. LGB&T people are also at significantly higher risk of mental disorder with higher rates of anxiety, depression, self- harm and suicidal behaviour as well as higher drug and alcohol use[12]. Mental health issues often relate to homophobia (including internalised homophobia) having a profound effect on self -esteem,

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[25] All Ireland Traveller Health Study 2010 (P87)

[26] Cooperation And Working Together (CAWT) is a partnership between the Health and Social Care Services in Northern Ireland and Republic of Ireland, which facilitates cross border collaborative working in health and social care

[27] Analysis of staff audits – Mental Health Services in WHSCT, HSE West and HSE (DNE).

[28] Factors impacting on Access to Health and Social Care Services. Literature review on traveller health CAWT 2013.

discrimination, family rejection and isolation. Other issues include access to services and attitudes. There is also a lack of awareness and understanding resulting in behaviour by health staff that can be profoundly humiliating.

A review of lesbian and bisexual women's health in Northern Ireland[29] found that lesbian and bisexual women experience significant barriers to accessing health services. While lesbian and bisexual women do experience the same health issues and problems as other women, the social and cultural context of lesbian lives are specific to this community and affect their access to health care, which potentially affects long-term health outcomes. For example, they are more likely to delay treatment and follow-up, be less compliant with cervical screening recommendations and are up to 2-3 times more likely to attempt suicide and have higher levels of self- harm than their heterosexual counterparts.

CAWT has undertaken a literature review of People LGB&T people[30] in relation to poor access to healthcare which reported the following:

- Healthcare providers' anti-gay bias and heterosexism and structural and attitudinal lack of knowledge on the part of healthcare providers.
- Fears, real or perceived of negative consequences.
- Concerns about staff.
- Confidentiality and experience or fear of homophobia when dealing with healthcare.
- Lack of knowledge of transgender issues among healthcare staff.

6.4 Black Minority Ethnic Groups (BME)

Barriers identified across a number of areas in relation to access by disadvantaged groups such as BME include the following[31].

- Difficulties accessing existing services by those who speak little or no English.
- A significant level of racism and racial harassment (both direct and indirect, individual and institutional racism).
- Low uptake of GP registration amongst Black and Minority Ethnic groups.
- A general lack of awareness as to what services are available.
- The need for more staff training and cultural awareness in issues relevant to e.g. BME people.
- A failure to meet even the most basic cultural needs of BME people (such as dietary requirements or religious observance).

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[29] Quiery M. Invisible women. A review of the impact of discrimination and social exclusion on lesbian and bisexual women's health in Northern Ireland. Belfast, 2007.

[30] LGBT Literature review on access to healthcare. CAWT 2013

[31] Connolly (2002:7) cf: Ethnicity Equality & Human Rights (section 3). Literature Review. Access to Health and Social Services in Northern Ireland DHSSPS 2006.

Screening, treatment, palliation and cancer services are not always accessible and sensitive to the needs of ethnic minority or disadvantaged groups. Some specific areas affected in relation to poor access are:

- A&E
- maternity
- mental health
- screening;
- use of GPs in primary care

There is also poor provision of certain services required specifically for ethnic minority groups, e.g. sickle cell disease among people of West African origin and West Indian descent, and thalassaemia among populations of South Asian and Mediterranean origin[32].

Different migrant groups, depending on country of origin, bring different challenges in relation to issues of health protection (TB, Hep B, Hep C, HIV), vulnerability to non communicable diseases, experience of health care (immunisation, prevention, screening, treatment), cultural beliefs about health/illness and acceptability of treatments. Experiences from their country of origin (e.g. conflict, war, torture) have a lasting impact. Many migrants experience discrimination and are disadvantaged in relation to the wider determinants of health[33].

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[32] Cooperation and Working Together (CAWT) literature review on LGBT people 2013; Shout 2003, Young Life and Times Survey 2009.

[33] Fit and Well. Changing Lives – 2012-2022.Strategic Framework for Northern Ireland. A Consultation Document DHSSPS; Centre for Social Justice, 2011.

7.0 Meetings with Organisations

Meetings were held with HSC staff, equality leads, Personal and Public Involvement (PPI) representatives, leads in public health, health improvement and health promotion within HSC trusts and the Public Health Agency as well as representation from voluntary organisations. The Northern Ireland Ambulance Service (NIAS) trust was not included in this scoping exercise. Other information was obtained from referenced sources within this document.

Meetings with non -statutory groups included staff from the Simon Community representing homeless people; the Rainbow Project for LGB&T and the Northern Ireland Council for ethnic minority groups (NICEM). Traveller representation was made through the trust's PPI leads and Co-operation and working together (CAWT).

7.1 HSC Trusts

Trust equality leads provided information that they meet on a regular basis through the DHSSPS Equality and Human Rights Steering Group. This group supports all HSC organisations in NI to tackle inequalities in the delivery of services. Specific activities of the group include providing guidance, support and advice on matters surrounding Section 75 duties of the NI Act, the Human Rights Act and any cross cutting policies and strategies.

The membership comprises representation from DHSSPS, HSC trusts and other agencies. The group is chaired by the head of the DHSSPS regional Strategy & Public Safety Directorate and the group meets every 6 weeks and more often if necessary.

Southern Health and Social Care Trust (SHSCT)

Meetings were held with the CAWT project co-ordinator involved in working with a range of disadvantaged groups. Another meeting was held with the Head of User Involvement and Professional Lead for Community Development within the trust to discuss user participation. The SHSCT produced a very comprehensive information pack to engage more effectively with service users and hard to reach groups. There is a PPI Panel as part of the Personal and Public Involvement structure to take forward the service user, carer and other stakeholder's agenda.

The trust submitted a progress update report (March 2012) showing a number of traveller support projects developed through a range of funding bodies. In December 2010, the SHSCT established a Trust Traveller Action Group to progress the recommendations emanating from this work study relevant to the Southern Trust. The group which meets every two months comprises representation from travellers and local traveller support groups together with trust staff. Travellers who had participated in the All Ireland Traveller Health Study as peer researchers were asked to join the group so that they could see the impact of the research and be involved in taking the recommendations forward in their own areas. Six travellers agreed to attend the meetings.

Belfast Health and Social Care Trust (BHSCT)

Meetings were held with trust staff in relation to their work on access to services for disadvantaged groups.

The trust has a strategy for improving traveller health and wellbeing (2011-2014) and established a Traveller Health Strategy Board, chaired by the Director for Social and Primary Care. The trust employs two part-time traveller health advocacy workers.

The rationale behind this approach is that through the traveller advocacy workers the trust will be able to assist travellers in making the best use of access to services, particularly in their use of those services previously identified in relation to disadvantaged groups.

An Munia Tober Community Health Programme is a local voluntary organisation providing support for the travelling community in Northern Ireland. For a number of years An Munia Tober has facilitated a traveller health programme. The community health programme at An Munia Tober consists of one health coordinator who designs and delivers a health programme in consultation with the traveller community, specifically traveller women. The trust currently employs a health visitor and a social worker to work specifically with the Traveller community. As well as fulfilling a generic health visiting and social work function, both members of staff have an extended role within the traveller community.

The BHSCT Traveller Health Strategy and Action Plan works with the travelling community to improve access to services and a trust steering group and operational sub group was set up to identify needs of the traveller community through consultation.

The BHSCT Ethnic Minority Health and Wellbeing Steering Group was established in 2011 with representatives from most of the services groups in the trust. In Nov 2011, the group carried out a mapping exercise to identify the services/activities being provided by the trust to ethnic minority communities/service users and this has been recently updated.

Community social workers also assess needs of service users from ethnic minority groups to identify if they meet the criteria to avail of trust service provision. For those people who do not meet the criteria, information and appropriate signposting (Including at times monies towards travel costs) are provided to ensure that individuals can access support when needed.

The BHSCT provides the regional interpreting service for primary and secondary care, which is a 24 hour interpreting service offering face-to-face interpreting in 33 registered languages. The translated welcome pack (2004) is printed in 19 different languages and provides information on hospital services.

The trust is part of a project led by the Northern Ireland Council for Ethnic Minorities (NICEM) in partnership with DHSSPS and the HSC Board to robustly capture critical patient/service user information which relates to the diversity of patients and service users to help HSC organisations plan, develop and enhance service provision. The trust also employs two traveller lay health liaison workers and provides travel and cultural awareness training. Through funding from the Public Health Agency the TB screening service within the BHSCT has developed the Northern Ireland New Entrant Service (NINES). This nurse led service aims to provide access to health care for new entrants to Northern Ireland including new immigrants, asylum seekers, refugees and clients who are unable to register for GP services. The service offers Mantoux testing and BCG vaccination for children and infants identified through the “at risk” screening programme.

A range of clinics can be accessed to address the health and social well-being needs of the client group including drop-in clinics for advice and support, health assessment clinics, immunisation clinics and health promotion sessions. In future months, clinic sessions will be further developed to include a GP clinic and a consultant led paediatric clinic. Clients are offered a holistic health assessment; screening for communicable diseases such as HIV, Hepatitis B and Hepatitis C for clients from high risk countries, and immunisations as required. Assistance is given with registration for GP and dental services; signposting to other services and onward referral as appropriate.

Northern Health and Social Care Trust (NHSCT)

The NHSCT is currently undertaking a review of their PPI Strategy and produces an annual PPI report to show how they have been engaging with service users.

The trust have indicated a need for guidance regarding the entitlement of people who are homeless. Within the trust there is a document entitled Enhancing Health Care for the Homeless (ECHO): An Integrated Approach. This initiative is a partnership between ECHO, Primary Care, NHSCT, Northern Ireland Housing Executive (NIHE), Public Health Agency (PHA), Combating Homelessness in Northern Ireland (CHNI) and other Voluntary and Community Organisations working with the homeless.

In the document which sets out the major principals for change there is particular reference to the following;

a) Safeguarding the most vulnerable in society.
b) Working together to achieve integrated care.
c) Focusing on prevention and tackling inequalities.

A Programme Steering Group has been established with a number of aims which include the development of a regional strategy for people affected by homelessness, and to advocate on behalf of people affected by homelessness to improve access to health and social care services. Within the trusts Equality Scheme Action Based Plan (1 May 2011 to 30 April 2014) a range of measures to improve access to services, communication and information, is included with information as to how these will be taken forward also provided. The trust has produced a report outlining barriers to accessing mental health services.[34] Of the key findings the research highlighted a lack of awareness among BME people as to what mental health services are available or how to access them. Only 56 per cent of survey respondents said they would be comfortable going to their GP for help with a mental health problem. A similar proportion (55 per cent) would be comfortable going to the NHS.

South Eastern Health and Social Care Trust (SEHSCT)

The trust has a two year action plan which includes a number of actions to address areas relating to inequalities. These include specific action measures to improve access to services. Some of the actions include identifying gaps in information provision as highlighted in the trust inequalities audit and to providing information in accessible formats to meet the needs of BME (Black Minority Ethnic) communities. The action plan also highlights the need for greater awareness among HSC staff about Section 75 issues. In the trust there is currently no focus on travellers or homeless people although there is a focus on disadvantaged groups relating to BME/LGB&T people. The trust also has a PPI regional forum to provide assurances that they are involving disadvantaged people in their programmes of care.

Within the trust plan, in common with all other trust action plans, an inequality has been identified for persons in need who are destitute and have no or limited recourse to public funds. The trust has endorsed the need to agree and implement the HSC action plan in order to meet its responsibilities to homeless & potentially destitute non UK Nationals. This also includes providing training for staff in relation to the human rights of homeless non UK Nationals

There is also a disability action plan in place which has been endorsed by all other HSC trusts.

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[34] Barriers to Accessing Mental Health Services Views of Black and Minority Ethnic People in Ballymena Borough. Report compiled by Eoin Rooney in Partnership with Ballymena Inter-Ethnic Forum and Northern Health and Social Care Trust. March 2013.

Western Health and Social Care Trust (WHSCT)

The WHSCT, in line with other trusts has an Equality Action Plan which is being progressed over the next three years (1 May 2011 – 30 April 2014). Actions are monitored for progress and regularly reviewed to identify any additional requirements or to identify gaps in information provision for people from BME communities. Some of the actions identified within the plan are to:

- Produce information pack for new parents from BME communities.
- Raise awareness and improve equality of access to maternity and health visiting services.
- Lead a pilot and share learning regarding the development of common ethnic monitoring information available on identified Health and Social Care information systems.
- Work in partnership with Rainbow to carry out research on LGB& T experiences with specific services e.g. sexual health services and mental health services.
- Establish current experience of LGB &T patients and clients at GP/Fertility/GUM Services and Sexual Health Services.

The meeting with the trust equality lead involved discussion around the trust completion of an audit of inequalities. The meeting highlighted some issues in relation to the complaints system within trusts which were in relation to:

- staff attitudes
- access to services
- communication/information barriers
- equality in treatment and care

Further issues have been raised around GP access, specifically for children from migrant families who were not registered with a GP. Also included are institutional racism and health specific issues.

The trust’s annual progress report to March 2012 referenced the CAWT Social Inclusion Programme whose aim is to improve the health status and reduce health inequalities of travellers, vulnerable women and ethnic minority groups. The trust has also engaged with the HSCB to develop a regional strategy for minority ethnic interpreting services to ensure consistency and good practice and also ensure that the service and dedicated resources meet the needs of the increasingly ethnically diverse population in Northern Ireland. The trust report also referred to the Regional Equality and Human Rights Steering Group and key issues that included the need for Diversity Training; Ethnic Monitoring; Sexual Orientation Action Plan (under discussion with LGB&T groups); and an Accessible Information Policy (currently being drafted).

7.2 Disadvantaged group representatives
Lesbian, Gay, Bisexual and Transgender (LGB&T)

A meeting with Rainbow project staff endorsed many of the findings within the literature in relation to LGB&T experiences in accessing healthcare. Some of the highlighted findings were the increased risk of mental health issues amongst the LGB&T community with an increased misuse of drugs and alcohol and greater risk taking behaviour in areas of sexual health. An increase in STIs within the gay community was also highlighted.

Through funding from the PHA, the BHSCT provided a gay sauna to enable STI services to be delivered to those who do not usually attend mainstream GUM clinics which was found to be very beneficial to those who used it. However, this service has been discontinued. The Rainbow Project staff indicated it would be useful for them to be able to access STI/HIV surveillance data held by the PHA in relation to this area.

Some of the problems reported by members of the LGB&T group included being able to access treatment from medical staff for post exposure prophylaxis so that this occurs within 72 hours of exposure as per the DHSSPS guidelines endorsed by The British Association for Sexual Health and HIV (BASHH)

Staff at the Rainbow Project reported experiencing more barriers in accessing services through primary care as there was sometimes bias in staff attitudes towards members of the LGB&T community.

Within the Public Health agency there is on-going work to try to address the needs of LGB&T people and there is a consortium led by the Rainbow Project as well as an LGB&T HSC staff forum that meets on a quarterly basis. The PHA has an LGB&T action plan with some non-recurrent funding for work in this area.

Staff at the Rainbow Project were particularly concerned that there is currently no monitoring of access to services for LGB&T (or any other groups) thus making it impossible to know how the service is being used.

7.3 Homeless People

A meeting was held with the manager of the Simon Community in South Belfast. The Simon Community is a voluntary organisation which provides emergency accommodation, advice and community support for people who are homeless or those who are at risk of becoming homeless. They have a range of services to meet needs associated with being homeless.

The Simon Community assessment centre on the Malone road is aimed at young single homeless people aged between 17-26 in need of housing. The centre accepts self- referrals and referrals from any agency. Most agency referrals are from Social Services, Probation, Northern Ireland Prison Service, and the Police Service Northern Ireland. The length of stay for people can vary between 3 months and 3 years, with an average of 18 months. Other centres are located on the Falls road, Cliftonville avenue and Saintfield road for those people between the age of 17-65. Conway Court on the Falls road is orientated towards families who are homeless. The Simon Community also has a crisis orientated centre on the Falls road and drop in centre. Outreach is also provided on the streets and a night shelter provided by the Salvation Army.

Issues experienced by those who are homeless include an increase in self-harm, alcohol abuse and risk of suicide. The Simon Community in Belfast has links with the BHSCT, (although no other HSC trusts), and the BHSCT has a homeless support team run through a community nursing programme. There is also a Community Pharmacist Scheme which addresses men's health issues.

One of the difficulties experienced by those who use the Simon Community is not having an address to be able to access health services. The Simon Community will permit their centre address to be used to enable people to access GP services.

The BHSCT homeless team service provides public health care services for single homeless people living in temporary hostel accommodation, and sleeping rough in Belfast. The aim of the service is to improve the health and health care experience of this group of people.

7.4 Black Minority Ethnic (BME)

Migrant and Black and Minority Ethnic (BME) communities in Belfast represent a diverse and dynamic population in terms of their reasons for migration, with changing health needs and priorities over time. The largest, most established minority ethnic community in Belfast is the Chinese community, followed by Indian and Pakistani populations.

A meeting was held with the Executive Director of the Northern Ireland Council for Ethnic Minorities (NICWM). The meeting highlighted the frustrations experienced by some ethnic minority communities in relation to health access, e.g. waiting for a GP for longer than 2 weeks. A paper was commissioned by NICEM (2010) on the health of Black and Minority Ethnic communities in Northern Ireland.[35] This reviewed regional, national and international research reports on BME health and social care which had been published during the previous decade. One of the key issues commented on within the paper was that:

"Each research report tends to reinforce what others have recommended. It is frustrating for those working in the area of racial equality in health that most

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[35] NICEM. January 2011.

reports contained consistent and duplicate recommendations, but little has been done to remove the barriers to access health and social care."

The paper highlighted that all recommendations were directly related to linguistic, cultural and religious barriers and that many focus on the provision of interpretation services. Most analyses also, whether based on qualitative or quantitative research (most are qualitative), cannot provide wider practical evidence to guide HSC Trusts in planning and developing services to meet the health needs of specific Black and Minority Ethnic communities.

7.5 Travellers

Currently there is no regional strategy for traveller health in Northern Ireland. However a lot of work has been undertaken particularly within the Public Health Agency, BHSCT and SHSCT in relation to supporting the health and social care needs of travellers. The SHSCT and BHSCT have a traveller strategy, action plan and traveller's workers/ traveller health posts. There is a broad aim to try and expand the number of trusts employing travellers. Currently there are 3 traveller support groups in SHSCT but there is no clear recurrent level of funding support attached to this initiative.

There is also a regional traveller health and wellbeing forum**.** The PHA has thematic action plans in relation to travellers/BME/homeless people and meetings are held on a quarterly basis to review progress against these action plans. The SHSCT has been very active in engaging with travellers but also recognises the need for further capacity building.

The SHSCT forms part of the CAWT area which aims to address some of the health issues experienced by the people who live in an area which has been identified as having greater deprivation. Some of the focus of this work has developed from the All Ireland Traveller Health Study a report of which was launched on the 2 September, 2010. The summary of findings report highlighted a number of key points which the Department of Health, Social Services and Public Safety (DHSSPS) and the Department of Health and Children (DOHC) were required to consider and take forward appropriately in conjunction with Health and Social Care bodies and other Government Departments.

Some of the key points included the following:

- a strategic action plan should be developed
- adequacy of accommodation is essential
- all aspects of mother and child services merit top priority
- men's health issues need to be addressed specifically (men are dying 15 years younger than their settled counterparts)
- there is a concerted need to address cause-specific issues for respiratory and cardiovascular disease.

8.0 Conclusions

Within many of the public health strategic reports it is recognised that the health gap is widening so that disadvantaged groups are more likely to have reduced life expectancy and overall poorer quality of life than other groups. There is ongoing work in the statutory health sector to improve access to services for disadvantaged groups. This work is regularly monitored by the Equality Commission in NI through HSC Trust action plans which are submitted to the Commission under Section 75. Although trusts have individual strategies for disadvantaged groups such as for travellers, currently there is no regional strategy. Also, allocated funding is not mainstreamed for much of the work carried out through the Public Health Agency. It may therefore be of benefit to have funding streams for disadvantaged groups which may help to address the Public Health Agency (PHA) approach with the HSCB to reducing inequalities and improving health and wellbeing
In order to build substantive communities.

Some of the barriers to access to services for groups have been identified as being in relation to the provision of information and in making it more accessible so that people are aware of who they can contact and how they can use the services. There are also other more fundamental issues around language and cultural factors. However, some ethnic minority groups believe that statutory bodies need to look beyond this and find ways to better plan and develop services to meet a more diverse population.

Some other barriers identified by CAWT in recent literature reviews carried out by the SHSCT found issues in relation to negative stereotypes, poor communication, staff attitudes and embarrassment as reasons why disadvantaged groups are reluctant to access services.

Some services are used more frequently by disadvantaged groups' e.g. maternity, mental health and A&E. However, within the BME groups some of these i.e. ROMA (made up of Romanians, Bulgarian, and Czech people) are currently unable to register with GPs. However this restriction will cease from December 2013 and from 2014 full access will be given.

Disadvantaged groups are strongly in support of HSC trusts bringing in ethnic monitoring so that there is better evidence of how these groups use or underutilise services. This work is currently being undertaken and being rolled out to e.g. the Child Health System and other areas and ethnic monitoring posters and leaflets and guidance for staff have been made available in relation to this initiative. It is hoped that this will provide a means to show how services are being used or underutilised by a range of disadvantaged groups.

Section 75 has nine categories which encompasses ethnic groups. However, there is no specific reference to homeless people and it is left up to individual trusts to decide how to best meet their health needs to ensure access to services. In terms of public authorities, they have a duty to "have due regard to the need to promote equality of opportunity" which is a primary duty. There is also a good relations duty which should act to reinforce equality and serve the public in all its diversity.

The HSC trusts have been very actively involved in addressing the needs of disadvantaged groups through work with travellers, LGB&T and BME groups. Much work has been undertaken into the needs of these groups and a regional strategy for older LGB&T has recently been developed.

However, although there is some on- going work within the trusts e.g. BHSCT has a homeless support team within community nursing, there is no regional strategy on homelessness within HSC services. Research has shown that this group are much more likely to have complex mental health and physical needs as well as social issues and are at greater risk of exploitation. In conclusion RQIA considers that in the future a review of health and social care services provided for homeless people could be carried out.

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