Terms of Reference

<table>
<thead>
<tr>
<th>Project Name</th>
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<tr>
<td>Health and Social Care Inequalities in Northern Ireland</td>
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Overview of the Request

Summary
The Equality Commission for Northern Ireland (hereafter ‘the Commission”) is working towards an update of its 2007 ‘Statement on Key Inequalities in Northern Ireland’\(^1\). To inform the development of this revised statement, the Commission is seeking to contract research on current health and social care inequalities in Northern Ireland, giving consideration to physical and mental health and well-being and access to health and social care provisions, which may affect relevant Section 75 groups across the nine equality grounds\(^2\). The identification of new or emerging inequalities that may affect the health of and/or may impede access to, and availability of, health and social care for Section 75 groups, considering those with multiple identities, should also be explored where relevant.

The Commission wishes to receive proposals from organisations, teams or individuals with relevant knowledge and expertise re: health inequalities; health and social care; barriers and enablers to same; relevant data sources and literature; data handling / analysis; and qualitative data collection (as appropriate). The contract is expected to be awarded in August / September 2015.

Context / Background
In October 2007, the Equality Commission for Northern Ireland published its Statement on Key Inequalities in Northern Ireland\(^3\). This statement identified health and social care as one of six broad areas where inequalities exist and need to be addressed; accepting the premise that improving equality in health services and health outcomes is a driver of economic and social well-being. The Commission’s 2007 Statement on Key Inequalities highlighted “Inequalities in Health and Social Care” as a key theme for action, noting the following priority issues:

- Access to health and social care services for migrant workers and new residents
- Accessibility of health and social care services to older and disabled people
- Attitudes of professional medical staff
- Inequalities in investment in mental health and learning disability
- Gender inequalities in access to health care
- Poor levels of health experienced by Travellers
- The impact of caring on health outcomes
- The social inclusion of older people

The Commission wishes to review and update the current evidence base with regards to inequalities in health and social care to inform a revised statement on key inequalities in Northern

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\(^1\) ECNI (2007) Statement on Key Inequalities in Northern Ireland, Available from: [http://www.equalityni.org/archive/pdf/Keyinequalities(F)1107.pdf](http://www.equalityni.org/archive/pdf/Keyinequalities(F)1107.pdf)

\(^2\) As defined by Section 75 of the Northern Ireland Act 1998 – gender, disability, age, dependant status, sexual orientation, racial group, marital status, religious belief and political opinion.

\(^3\) ECNI (2007) Statement on Key Inequalities in Northern Ireland, Available from: [http://www.equalityni.org/archive/pdf/Keyinequalities(F)1107.pdf](http://www.equalityni.org/archive/pdf/Keyinequalities(F)1107.pdf)
The project will build upon and compare the Commission’s 2007 statement with latest available data and research, to highlight the most substantial new and / or persistent inequalities in health and social care across each of the equality grounds. In support of this the contractor is expected to draw on an analysis of available and relevant quantitative datasets; health and social care statistical outputs; on recent, relevant academic knowledge of barriers and enablers to health and social care; and on additional sources of data from Northern Ireland (including Health sector audit of inequalities documents prepared as part of their Section 75 action plan) and other jurisdictions, where relevant and appropriate.

The completed project will present an analysis of relevant information to identify, for each of the grounds established by Section 75 of the Northern Ireland Act 1998, the key inequalities in health and social care faced by those groups and those with multiple identity issues. In addition, and drawing on this, the completed project will also identify the most substantive inequalities in health and social care in Northern Ireland across all grounds combined; shedding light on current equality gaps and providing an insight into whether we are observing persistent inequalities or whether changing trends are evident.

**Updating our Understanding of Key Inequalities**

The 2007 ‘Key Inequalities’ document was produced in very different circumstances to those which prevail today. At that time, the impact of the growing economy on health was noted “reflecting a new era for Northern Ireland’s prosperity”2. Since then, the social, economic and policy context of health and social care in Northern Ireland has changed, and all these factors impact on health and social care. The economic crisis and a background of reduced public expenditure has created a different environment3 for health and social care and the role it can play in promoting equality of opportunity and good relations in Northern Ireland. In addition, under the Review of Public Administration (RPA) health and social care services have undergone a substantial reorganisation of services leading to the amalgamation of the four Health and Social Care Boards into one Health and Social Care Board, the formation of the Business Services Organisation, Public Health Authority and the Patient and Client Council and the formation of realigned Health and Social Care Trusts to oversee the delivery of health and social care services in five regions of Northern Ireland (Northern Trust, Western Trust, Southern Trust, South Eastern Trust and Belfast Trust).

Health and Social Care in Northern Ireland has recently undergone reform in the way services are delivered, via the ongoing implementation of the “Transforming Your Care”4 policy and “Quality 2020”5 strategy. In addition, the “Fit and Well: Changing Lives”6 strategy aims to reduce inequalities in health and support the achievement of “full health potential and well-being” in Northern Ireland via public health intervention. Consideration is also being given to reform of the provision of adult social care.

Whilst 2015 presents a very different environment for health and social care provision in Northern Ireland, many of the key inequalities identified in 2007 are still as pertinent. In our 2013 response7 to “Transforming Your Care: From Vision to Action”, accessibility of health services for disabled and older people was identified, with the role of affordable, accessible transport highlighted as a key concern8. In addition, the need to take account of historical underinvestment in mental health and

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4 Health and Social Care Board (2012) Transforming Your Care: From Vision to Action. HSCB: Belfast
7 ECNI (2013) Summary Response to “Transforming Your Care: From Vision to Action” Consultation. ECNI: Belfast
learning disability and ensure ongoing investment commitments was highlighted. Traveller health is still a major and persistent inequality in Northern Ireland. The All Ireland Traveller Health Study has identified poor health, high infant and adult mortality rates as a persistent concern for Travellers with only 3% of the Traveller population in Ireland aged 65 years or over. In addition, the suicide rate of Travellers is 8 times that of non-Travellers. Further, the social inclusion of older people remains an issue, given that the proportion of those aged 85+ years is likely to increase by 51% by 2021.

Changes in the social, demographic and economic context of Northern Ireland have also presented new challenges to health and social care. For example, Northern Ireland has a growing and ageing population which is anticipated to lead to a growth in poorer health and chronic conditions and a resultant increased demand for and instability in health and social care services. This increased demand and instability may exacerbate existing inequalities or lead to the emergence of new/further inequalities in health and social care services. Amongst other trends, inequalities in mental health issues are also of increasing concern given the economic downturn, for example, suicide rates have increased in Northern Ireland with an increased rate of suicide associated with deprivation and rurality, particularly amongst men. In addition, the impact of health and social care reforms and public health strategies on inequalities in the provision of health and social care services is unknown and will require ongoing monitoring and evaluation now and in the future.

PROJECT SCOPE / REQUIREMENTS

Aim (Overall the project will achieve: )

To provide an up-to-date evidence base leading to the robust identification of new and/or persistent key inequalities in health and social care in Northern Ireland as a whole, and individually for each of the nine equality grounds.

Objectives (Completion of this project will result in: )

- For each equality ground identified by Section 75 of the Northern Ireland Act 1998 (and considering multiple identity issues), a comprehensive and updated picture (data permitting) of any key inequalities evident in patterns and trends in health and social care in Northern Ireland.
- For the identified key inequalities in health and social care, an overview of potential barriers and enablers including an assessment of any changing dynamics.
- A distillation from the above ground by ground consideration, of the most substantive overarching key health and social care inequalities in Northern Ireland.
- Involvement of relevant stakeholders via an expert seminar to explore and refine emerging findings of the research, with a view to informing the final report and associated recommendations.

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9 ECNI (2013) Summary Response to “Transforming Your Care: From Vision to Action” Consultation. ECNI: Belfast
10 All Ireland Traveller Health Study Team, School of Public Health, Physiotherapy and Population Science, University College Dublin (2010) Our Geels: All Ireland Traveller Health Study. Department of Health and Children: Dublin
11 Ibid
14 Ibid
15 Ibid
17 As defined by Section 75 of the Northern Ireland Act 1998 – gender, disability, age, dependent status, sexual orientation, racial group, marital status, religious belief and political opinion.
The following supplementary information is intended to assist potential contractors in the tendering process.

Scope

Inclusions

As noted above, the project will build upon and compare the Commission’s 2007 statement with latest available data and research, to highlight the most substantial new and/or persistent inequalities in health and social care across each of the equality grounds.

The project shall address:

1. For each equality ground identified by Section 75 of the Northern Ireland Act 1998 (and considering multiple identity issues), a comprehensive and updated picture (data permitting) of any key inequalities evident in patterns and trends in health and social care in Northern Ireland.

Beginning with a short consideration of pre-existing patterns and trends in health and social care inequalities, the research should provide a comprehensive review of relevant up-to-date health and social care sector data and associated relevant literature to set out key health and social care patterns and trajectories relevant to Northern Ireland.

It is the Commission’s view based on its experience with similar studies, that the preferred method of the research should be a review of existing data/statistical outputs relating to health and social care (for example DHSSPS and NISRA health and social care statistics), an analysis of quantitative data from secondary health and social care sources (where quantitative data outputs provide insufficient detail on Section 75 grounds) and a review of existing research. While potentially limited by time lags in publishing the latest data, this should assist in updating the current position in Northern Ireland and to monitor trends over time. Contractors should set out in their proposal the data sets they intend to use and the topics/grounds on which data is available/analysis will occur.

In addition, wider literature reviews for each equality ground should be undertaken to introduce and set in context the analyses and patterns/trends observed. Literature from Northern Ireland over time, or from other jurisdictions may help explain particular trends currently observed in Northern Ireland. In doing so, such analyses might usefully consider whether trends in Northern Ireland are new or persistent; or unique or similar to those observed in other jurisdictions, for example the RoI, GB and/or EU.

2. For the identified key inequalities in health and social care, an overview of potential barriers and enablers, including an assessment of any changing dynamics.

To provide insights into the above inequalities the research should highlight key issues relevant to improving physical and mental health and well-being and accessing health and social care provision in Northern Ireland for identified key inequalities. This should consider existing literature/research relevant to Northern Ireland, and if required, comparative analysis from other jurisdictions as appropriate.

Stakeholder Engagement

To assist in meeting objectives 1 and 2, the Commission considers that early engagement with key stakeholders is crucial.

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18 It is anticipated that breakdowns for each equality ground should also contain gendered breakdowns, where possible.

19 For example, DHSSPS Health and Social Care Inequalities Monitoring System, DHSSPS hospital statistics, DHSSPS Health Survey, NISRA Census 2011, DHSSPS Adult and Child Social Care statistics, Public Health Agency/NISRA Northern Ireland Longitudinal study and Northern Ireland Mortality Study, Business Services Organisation GP registration data, NISRA Continuous Household Surveys etc.

20 For example OECD provides international comparative health-related statistics - see http://www.oecd.org/statistics/
stakeholders is essential to inform the identification of key inequalities, barriers and enablers. The Equality Commission recognises the value of wider input to help understand the range of issues affecting different groups. This might be achieved through engagement with statutory, voluntary and community organisations, such as the Patient and Client Council, NICCY, COPNI, Patient Forums, Carers groups and community/voluntary sector representatives of other affected groups (e.g. older people and disabled people).

Early engagement with experts/stakeholder groups will assist in developing a wider understanding of specific barriers/enablers faced by groups in relation to health and social care in Northern Ireland at present. In addition, input from experts/stakeholder groups may provide local insights; reinforce or challenge findings obtained from analyses of quantitative data; or explain identified gaps within the quantitative data. Contractors should, in their proposal, set out who they intend to engage with and the steps they will take to ensure expert/stakeholder participation.

3. **A distillation from the above ground by ground consideration, of the most substantive overarching key health and social care inequalities in Northern Ireland.**

The information gathered and considered on inequalities by each ground should additionally be used to distil, **across all grounds combined,**

- the most substantive overarching inequalities health and social care in Northern Ireland, and;
- key overarching barriers and enablers associated with identified key inequalities and priorities for health and social care in Northern Ireland at present.

In particular, this would identify and provide evidence of those groups who are most likely or continue to experience the most substantive physical and mental ill-health issues and those with the greatest difficulties in accessing health and social care provision in Northern Ireland.

4. **Involvement of relevant stakeholders via an expert seminar to explore and refine emerging findings of the research, with a view to informing the final report and associated recommendations.**

The successful contractor is required to engage and review emerging draft findings with an extended range of stakeholders via an ‘expert seminar’ during the life of the project. This would be in addition to any liaising with experts/stakeholders as part of initial data/evidence gathering.

It is envisaged that the ‘expert seminar’ provide stakeholders an opportunity to understand, and suggest refinements to, the emerging findings reported for each equality ground.

Prospective contractors are invited to set out in their response to tender how they will incorporate the ‘expert seminar’ into this research project. (It should be noted that the Commission would undertake to facilitate the organisation of such an event and to cover reasonable venue costs locally. Finer details of the arrangements would be agreed within the Project Initiation Document). The contractor is expected to meet the costs of chairing/presenting the ‘expert seminar’. The contractor is also expected to factor, into their overall project tender cost, their own reasonable transport/accommodation costs associated with any events, such as the ‘expert seminar’, and any other stakeholder engagement.

5. **Final Reporting**

The final reporting will consider for each equality ground a comprehensive and updated picture (data permitting) of any key inequalities evident in patterns and trends in health and social care in Northern Ireland and an overview of potential barriers and enablers to health and social care for identified key inequalities including an assessment of any changing dynamics.

The report on “Inequalities in Health and Social Care in Northern Ireland” will represent one of a series of reports across a range of themes on key inequalities in Northern Ireland. Therefore, to ensure consistency across reports, the Commission will insist that this and all reports adhere to, or are very similar to (given the differences in sectors), an already agreed format and structure for the
In broad terms the report must provide an equality ground by ground analysis, which then informs an overarching consideration of key inequalities and associated conclusions and recommendations.

**Additional Points**
Potential contractors should take account of the Commission’s ‘Response to Tender Guidelines, when developing and submitting their proposals.

To assist in their demonstration of their ‘understanding of the literature and requirements’ for the project and their ‘expertise and experience’ in the area, the contractor should, amongst any other points they consider relevant, clearly identify in their proposed ‘methodology', what health and social care provisions and measures of well-being they will examine; the data to be analysed; what methods of data analysis will be undertaken; and, where they will obtain that data.

**Exclusions**

The Commission is interested in updating the evidence base on groups experiencing / most likely to experience inequalities in health and social care in Northern Ireland and how these inequalities manifest themselves. The Commission appreciates that there may be a lack of quantitative data available for groups within the nine grounds. It is not anticipated that this project will collect extensive primary quantitative research to address identified gaps, however appropriately collected qualitative data may serve to provide insights where quantitative data is not available.

The research will not seek to conduct an in-depth statistical analysis of health and social care data from comparable jurisdictions. However, it should consider literature and high level trend information analysis from these jurisdictions so as to place any patterns observed in Northern Ireland within their wider context.

This research does not intend to develop strategies for the groups identified as disadvantaged – it is intended to provide patterns and trends in health and social care in Northern Ireland; the ground/group issues evident in Northern Ireland; emerging/ongoing issues for affected groups within Northern Ireland; and to identify barriers and enablers to improving physical / mental health and well-being and accessing health and social care provisions for identified key inequalities. However, the contractor could set out in their bid how they might bring to the Commission’s attention any significant recommendations that emerge through the course of the research.

**Potential data sources**

Health and social care statistics are drawn from a range of administrative, census and survey-based resources available from a range of data providers including the Department of Health and Social Services and Public Safety (DHSSPS), NISRA, the Public Health Agency (PHA), the Health and Social Care Board (HSCB), Business Services Organisation (BSO), the Patient and Client Council (PCC) and individual Health Trusts.

It is envisaged that statistical outputs and data analysis in the following broad areas will be relevant:

- **Access to health provisions** (for example, access to quality inpatient / outpatient treatment, waiting times, access to quality maternity services, access to quality GP services, 21

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21 The project is not limited to any examples set out in this section and the contractor should only include those elements which they feel have merit and relevance to their proposed approach.
experiences of treatment/care etc.)

- **Access to social care provisions** (for example, access to community-based care, access to quality residential and nursing care, direct payments, looked after children, carer’s assessments etc.)

- **Physical and mental health and well-being** (for example morbidity, mortality, life expectancy, suicide, obesity, child health, risk behaviours and health behaviours etc)

Where the contractor anticipates using the Honest Broker Service\(^{22}\) to access data the contractor should highlight the potential impact this will have on the timeline of the project.

During the life of the project, members of the project Advisory Group may be available to provide guidance on, and potentially access to, possible data and information sources.

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**Contractor Expertise / Experience**

In addition to any other element they feel relevant, prospective contractors should demonstrate their relevant expertise/experience\(^{23}\) regarding:

- patterns of, and barriers and enablers to, health and social care;
- relevant data sources and literature relating inequalities in health and social care in Northern Ireland;
- quantitative data handling / analysis and qualitative data collection / analysis (as appropriate);
- stakeholder engagement (for research purposes).

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**PROJECT DELIVERABLES**

**What Deliverables are required? What must they contain?**

The following documents must individually and collectively meet the required standards for acceptance\(^{24}\) by the Commission.

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<tr>
<td><strong>Draft Final Project Initiation Document</strong></td>
<td>The document will incorporate the detailed scope of the study, roles and responsibilities, assumptions, risks, deliverables, reporting and timing. The contractor shall meet with the Commission’s Advisory Group to discuss the same.</td>
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<tr>
<td><strong>Project Initiation Document</strong></td>
<td>The document will incorporate the detailed scope of the study, roles and responsibilities, assumptions, risks, deliverables, reporting and timing. This document will be agreed upon by the Commission following consideration by an Advisory Group and the project shall be deemed to commence upon acceptance by the Commission of the Project Initiation Document.</td>
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\(^{22}\) [http://www.hscbusiness.hscni.net/services/2454.htm](http://www.hscbusiness.hscni.net/services/2454.htm)

\(^{23}\) See the accompanying “Response to Tender Guidelines” for further information.

\(^{24}\) In producing reports and deliverables, the contractor shall be required to meet quality requirements as set out within an agreed contract and PID. The contractor will also be required to adhere fully to the Commission’s style guide, which outlines requirements with regard to written submissions.
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| Interim Data Report                | The document will include copies of any data requests made to data holders. In making a request to data holders the contractor must ensure that the data holder is aware that the research is being undertaken on behalf of the Commission and as such the Commission will also have access to the data. The Commission agrees to uphold any restrictions placed upon the data by the data holder.  
  The Data Report will also summarise the data received from the data holder alongside any caveats the data holder has placed upon the data. Additionally, this document will provide details of how the contractor plans to validate and use the data.  
  The data files shall accompany this report. However, the Commission recognises that data will be collected at various points over the life cycle of the project and will expect updated data files as they become available.  
  The contractor shall use the template for the Interim Data Report that can be found as Appendix 1 to this document. |
| Interim Report                     | An Interim Report comprising of two main parts – a summary of activities undertaken and outstanding; and an annotated draft final report structure (chapter headings and key arguments / findings) capable of delivering the aim and objectives of the project and supplemented with project background, findings to date and emerging recommendations; meeting the required standards for acceptance by the Commission |
| Expert Seminar                     | An Expert Seminar should take place where the contractor shall present findings of the research and engage on recommendations arising from the same with an audience of relevant stakeholders, with a view to informing the draft final report and associated recommendations. |

**Draft Final Deliverables**

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| Draft Chapter                      | A Draft Chapter shall be provided to the Commission in advance of the Draft Final Report to provide an opportunity for early feedback to the contractor. This will follow the structure agreed upon in the Interim Report.  
  Any data files relevant to the Draft Chapter should be provided to the Commission to aid quality assurance procedures. |
| Draft Final Report(s)              | The Draft Final Report shall deliver on the aim and objectives of the project as specified, and should reflect the following generic format: executive summary, background, aims & objectives, methodology, findings, discussion, conclusions and recommendations. The Draft Final Report shall take onboard comments and suggestions made by the advisory group with regard to the Draft Chapter. |

**Final Deliverables**

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| Final Data Report and Data Provision | An updated Data Report shall be provided alongside the Draft Final Report. This report shall include any additional data requests made to data holders not already reported upon during the Interim Deliverables stage of the project. As this is an update on the Interim Data Report, the template for the Interim Data Report, found as Appendix 1 to this document, shall be used for this purpose.  
  The main body of this report shall focus on providing the Commission with details on how the data collected has been cleaned, validated and utilised in the writing of the Draft Final Report. |
Data files shall accompany this report; these will include the contractors own data files and any corresponding charts.

**Final Report**

The Final Report shall deliver on the aim and objectives of the project as specified, and should reflect the following generic format: executive summary, background, aims & objectives, methodology, findings, discussion, conclusions and recommendations.

The Final Report should be a minimum of 30,000 words.

The Final report - shall be with the Commission within 3 weeks of the Advisory group providing feedback on the Draft Final Report.

**Summary Report**

A separate stand-alone summary version of the research (3,000 -4,000 words/10 pages), suitable for interpretation by a lay audience (and proofread for typographical and grammatical errors by the contractor), which fully summarises the research aims, processes, findings and recommendations – shall be with the Commission within 3 weeks of the Commission accepting the final report(s).

**Presentation**

A verbal presentation with associated visual aids (PowerPoint or similar) which fully summarises the research aims, processes, findings and recommendations – shall be given to an audience of the Commission’s choosing at a date within 12 weeks of acceptance of the final report.

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**Proposed Budget**

The budget for this project should be in the broad range noted (including VAT and expenses).

Payment arrangements will be as follows:-

- A first payment, 40% of the total project fee to be paid on commencement of the project following acceptance of the Project Initiation Document;
- A second payment, 20% of the total project fee to be paid on acceptance of all Interim deliverables; and
- A final Payment, 40% of the total project fee to be paid on acceptance of the final deliverables and associated presentation.

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<td>Up to £25,000</td>
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