

# **Equality Impact Assessment**

On

## **General Practice Policies:**

**GP Trainer Selection  
GP Retainer Scheme**

By

**Northern Ireland Council for Postgraduate Medical  
and Dental Education  
(NICPMDE)**



**Final Report  
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## **Executive Summary**

This document reports the outcome of an Equality Impact Assessment (EQIA) by the Northern Ireland Council for Postgraduate Medical and Dental Education on General Practice (GP) policies (encompassing the two policies of GP Trainer Selection and Selection of GP Retainer Supervisors).

The EQIA was carried out with reference to the Equality Commission's 'Practical Guidance on Equality Impact Assessment' (Equality Commission 2001a).

This document will be made available on request in formats such as Braille, audiocassette, large print, and disc and in minority languages to meet the needs of those not fluent in English.

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### ***The Organisation***

The Northern Ireland Council for Postgraduate Medical and Dental Education (NICPMDE) was established in 1970 and re-constituted in 1994. It is responsible for funding, managing and supporting postgraduate medical and dental education within the Northern Ireland Deanery.

## ***The Policies***

### **GP Trainer Selection**

The policy is concerned with the process of selecting GPs to become trainers for GP Registrars. There are currently 93 accredited GP trainers in Northern Ireland, who are responsible for delivering training to GP Registrars within their practice. To be accredited as a training practice, a GP practice is required to meet national criteria for the selection/re-selection of GP trainers, issued by the Joint Committee for Postgraduate Training in General Practice (JCPTGP), the national body which sets the standards and regulations for GP training in the UK.

A GP must be a Principal for three years before they can apply to become a trainer. If a GP is interested in becoming a trainer she/he is required to attend a 5-day course for new trainers. A potential trainer must pass a Summative Assessment following the course. If there is no trainer in the practice, a practice visit is undertaken. New trainer and training practice appointments are approved by the Trainer Selection Committee.

### **Selection of GP Retainer Supervisors**

The GP Retainer scheme aims to give doctors the opportunity to work during a stage when they are not able to make a full-time commitment to general practice. Each retainee has a named educational supervisor to act as mentor in the practice. Practices wishing to employ a Retainer are required to meet minimum criteria. Training practices are automatically eligible to become retainer practices. Doctors who have received the Director's approval to join the scheme as a GP Retainer are given a list of retainer scheme practices. It is their responsibility to contact a practice and arrange their sessions, then inform Council of the details. The Council does not allocate GP Retainers to practices. Practices are generally chosen on the basis of location. If a Retainer wishes to work in a non-training practice, the Director visits the practice before they begin to check that the practice meets the minimum criteria.

## ***Data Collection and Consultation***

The Council conducted a survey of all GP trainers and GP Retainer supervisors to collect data on age, gender, religion, dependants, marital status, ethnicity, and disability. Moreover, a questionnaire was sent to all GPs providing them with the opportunity to express their views and suggestions on equality of opportunity regarding both schemes.

The consultation period lasted for 11 weeks from 29 November 2002 to 14 February 2003. The chosen method focused on soliciting written responses. Letters were sent out to all GPs in Northern Ireland, providing them with a summary of the report as well as details on how to access the full report and inviting them to comment on the EQIA. In addition, the NICPMDE approached the British Medical Association to comment on the report.

Finally, a pro forma was sent to all organisations on the consultation list, inviting responses to a set of focused questions (see Appendix 4).

## ***Key Findings***

The assessment is based on the analysis of both quantitative and qualitative data. While the response rate to the conducted survey of all GPs is comparably low (5% of all GPs) and thus caution has to be taken regarding the wider interpretation of the results, the NICPMDE values the feedback provided by those who offered their views.

In the following, the main findings from the research are summarised and assessed.

- Female GPs do not participate evenly in the GP Trainer scheme nor in the GP Retainer Supervisor scheme. GPs argue that this is in large parts due to the exclusion of part-time GPs from the scheme, who are predominately female. *The assessment of these findings suggests a misconception amongst some GPs regarding the eligibility criteria for the two schemes. The Criteria for Selection/ Reselection state that part-time GPs are acceptable to train a full-time Registrar provided they work no less than 19 hours a week*

*in the practice and that within the practice there is either an adviser, another trainer, a course organiser or a senior member of the Department of General Practice, otherwise a part-time trainer may train a part-time Registrar. These criteria are meant to ensure that a trainer is present at all times for the Registrar. The Council has considered the suggestion to facilitate joined training by practices where only one part-time trainer is present; it has concluded that this would not be in the best interest of Registrars.*

- *The quantitative analysis clearly underlines that older people are less likely to act as GP Trainers and GP Retainer Supervisors. This conclusion is endorsed by the perception of GPs. The age limit of 50 specified in the selection criteria for first appointments appears to act as a clear discriminatory barrier. However, self-discrimination may likewise play a role (GPs in older age groups may resign from their function as a trainer or supervisors).*
- *Neither persons with a disability nor people from a black and minority ethnic background participate in either of the two schemes. However, in the absence of comparator data for the GP population as a whole there is no clear evidence of this being due to adverse impacts of the policy itself. It is unlikely that the percentage of either disabled people or people from a black and minority ethnic group is substantially lower amongst trainers and applicants as well as Retainer supervisors than amongst all GPs. In fact, the Council is aware that members of a black and minority ethnic group have participated in both schemes in the past. Any interpretation of quantitative data on disability has to bear in mind the likelihood of under-reporting.*
- *Hardly any single people or people without dependants are to be found amongst GP Trainers and GP Retainer Supervisors. In the absence of*

comparator data, it is impossible to determine whether this is due to adverse impacts of the policy itself. *It is more likely, however, that this reflects the skewed age structure of participants.*

- The comparison between those who are eligible to act as supervisors for GP Retainers and those who are currently acting as supervisors reveals that Retainers are more likely to pick male, young, Protestant GPs as supervisors. *Practices are chosen by Retainers themselves. Given that GP Retainers are usually women who have domestic commitments which prevent them from working full time, they usually choose practices from the pool which are closest to their homes irrespective of other factors.*
- Some GPs perceive a bias against rural and peripheral practices to be at work in relation to both schemes. *For a number of years now, the Council has operated a quota system specifically to ensure that training is fairly spread across the 6 Day release courses held in Altnagelvin, Craigavon, North Down, Broughshane, Antrim and Belfast. In relation to the GP Retainer scheme, the same basic fact has to be taken into account as in relation to the previous point: the fact that Retainers usually choose practices from the pool which are closest to their homes irrespective of other factors.*
- The majority of GPs surveyed explicitly endorsed the two schemes as being open and transparent. A significant minority, however, felt that information on the scheme is not distributed widely enough. *The Council disseminates information on the 'Learning and Teaching' Course as the first step to becoming a trainer to all GPs by means of a flyer.*

## ***Action Points***

The assessment suggests differential impacts of the two policies on two of the equality target groups: females and older people. Evidence of adverse effects on disabled GPs as well as GPs from black and minority ethnic groups necessarily remains inconclusive as data on these groups is not available for the GP population as a whole. No evidence emerged regarding adverse impacts depending on marital status, dependants, religious affiliation, political opinion or sexual orientation.

Taking on board the outcome of the research, the Council will undertake the following actions:

- The Council accepts that the age of 50 should no longer be a cut off point for becoming a trainer nor 60 for retirement. The proposal was brought to the General Practice Committee of the NICPMDE on 4<sup>th</sup> February 2003 for discussion. It was decided that the limits would be removed. Moreover, trainers above the age of 60 would be encouraged to involve a practice partner in training tasks.
- The Council will include a statement on future mailings that NICPMDE is an equal opportunities employer and that applications from female GPs, older GPs, GPs from ethnic minorities and GPs with a disability will be particularly welcome.
- monitoring data on the categories of age, gender, marital status, dependants, disability, ethnicity, and religion will be collected on a regular basis as part of the application process; once collected, this will allow monitoring of both successful and unsuccessful applicants to which the Council commits itself.

## ***Monitoring***

The delivery of specific action points in this Equality Impact Assessment will be monitored on an ongoing basis and the organisation's Annual Review of Progress will contain a report on the EQIA implementation.

The organisation will seek to put in place arrangements for quantitative monitoring in relation to the categories of age, gender, religion, ethnicity, marital status, dependants, and disability on an annual basis.

The organisation does not have any quantitative monitoring arrangements in place in relation to the categories of political opinion and sexual orientation. Options for qualitative monitoring with regard to these categories will likewise be explored in the course of the first quarter of the new financial year, pending also the publication of further advice by the Equality Commission.

The Council commits itself to revising the policies if monitoring shows adverse impacts.

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## **BACKGROUND**

### ***Organisational Background***

The Northern Ireland Council for Postgraduate Medical and Dental Education (NICPMDE) was established in 1970 and re-constituted in 1994. It is responsible for funding, managing and supporting postgraduate medical and dental education within the Northern Ireland Deanery. The Council, through its committees and sub-committees:

- organises, accredits and reviews educational and training activities for doctors and dentists;
- allocates funds to facilitate training and study leave;
- monitors quality standards in medical and dental education and training;
- provides a careers and information and advisory service for doctors in the training grades;
- advises on the needs of overseas doctors training in Northern Ireland;
- facilitates specialist training requirements including flexible training opportunities and training and research opportunities outside Northern Ireland;
- implements the vocational training schemes for medical and dental practitioners.

To reflect the different training pathways the Council is divided into three functional departments for the provision of training in:

- general practice
- dentistry
- the hospital specialties/public health medicine.

Overall management responsibility rests with the Chief Executive/Postgraduate Dean. There are currently 121 staff, including a large number of medical and dental professionals, on the payroll of the Council. Thirty-five members of staff are based at Council Headquarters.

The NICPMDE is accountable to the Department of Health, Social Services and Public Safety from which it receives its financial allocation. The Postgraduate Dean has also a line of accountability to Queen's University Belfast for the administration of the pre-registration house officer year.

### ***Equality Impact Assessments***

Section 75 of the Northern Ireland Act 1998 has placed the following statutory requirements on each public authority.

1. *A public authority shall in carrying out its functions relating to Northern Ireland have due regard to the need to promote equality of opportunity –*
  - (a) *Between persons of different religious belief, political opinion, racial groups, age, marital status or sexual orientation;*
  - (b) *Between men and women generally;*
  - (c) *Between persons with a disability and persons without;  
and*
  - (d) *Between persons with dependants and persons without.*
2. *Without prejudice to its obligations under subsection (1), a public authority shall in carrying out its functions relating to Northern Ireland have regard to the desirability of promoting*

*good relations between persons of different religious belief, political opinion or racial group.*

A key practical element of the statutory equality duties is that public bodies should assess the impact of their policies and procedures on the promotion of equality of opportunity and good relations. This is practically carried out by initially assessing the equality implications of a policy or procedure, called screening. Those policies assessed as having equality implications should then be considered for an equality impact assessment.

An Equality Impact Assessment (EQIA) is a thorough and systematic analysis of a policy to determine whether or not that policy has a negative impact on groups or individuals in relation to one or more of the nine equality categories. The stages of an EQIA are listed in Appendix 1.

### ***The Policies Subjected To an Equality Impact Assessment***

#### **The Policy on GP Trainer Selection**

The policy is concerned with the process of selecting GPs to become trainers for GP Registrars.

Each year, 42 new GP Registrars are trained in Northern Ireland. Standard training lasts for 12 months (from August to July). Each Registrar is assigned to a training practice where they are based for 4 days each week.

There are currently 93 accredited GP trainers in Northern Ireland, who are responsible for delivering training to GP Registrars within their practice. A number of practices have more than one trainer. These 93 individuals form a pool of GPs who can act as trainers. Each year approximately half of them (42) are 'active' i.e. they have a Registrar working in their practice. The trainers meet in area groups several times each year. It is these groups which decide who will be 'active' for the following year. Trainers normally take it in turns to be 'active'.

To be accredited as a training practice, a GP practice is required to meet national criteria for the selection/re-selection of GP trainers, issued by the Joint Committee for Postgraduate Training in

General Practice (JCPTGP), the national body which sets the standards and regulations for GP training in the UK.

A GP must be a Principal for three years before they can apply to become a trainer. If a GP is interested in becoming a trainer she/he is required to attend a 5-day course for new trainers. A potential trainer must pass a Summative Assessment following the course. If there is no trainer in the practice, a practice visit is undertaken. Practices are re-accredited every 2 or 3 years, based on a practice visit. New trainer and training practice appointments are approved by the Trainer Selection Committee.

The over-riding question of the EQIA relates to the degree to which the current policy and practice in relation to GP Trainer Selection by the Council meets the needs of the different equality target groups amongst GPs in Northern Ireland. It sought to explore whether access to the GP Trainer scheme is fair and open to the different groups of GPs.

### **The Policy on the Selection of GP Retainer Supervisors**

The GP Retainer scheme aims to give doctors the opportunity to work during a stage when they are not able to make a full-time commitment to general practice. There are 45 places and membership usually expires after 5 years.

Each retaineer has a named educational supervisor to act as mentor in the practice. Practices wishing to employ a Retainer are required to meet minimum criteria. Training practices are automatically eligible to become retainer practices. Doctors who have received the Director's approval to join the scheme as a GP Retainer are given a list of retainer scheme practices. It is their responsibility to contact a practice and arrange their sessions, then inform Council of the details. The Council does not allocate GP Retainers to practices. Practices are generally chosen on the basis of location. If a Retainer wishes to work in a non-training practice, the Director visits the practice before they begin to check that the practice meets the minimum criteria.

The EQIA focuses specifically on the selection of GP Retainer Practices within the Scheme. Equality issues will be addressed on the basis of named supervisors within these practices. Essentially, the EQIA will be based on a comparison of active GP Retainer

practices with the pool of practices eligible to act as GP Retainer practices as well as the entire pool of GP practices.

### ***Screening***

These policies had been screened for equality implications as required by Section 75 and Schedule 9 and of the Northern Ireland Act 1998. Equality Commission guidance states that the purpose of screening is to identify those policies which are likely to have a significant impact on equality of opportunity so that greatest resources can be devoted to these.

A series of screening consultation meetings – with representatives of voluntary organisations - carried out during 2001, identified the potential for differential impact arising from the operation of the policies.

Taking account of comments received during consultation it was decided to undertake an Equality Impact Assessment on the policies. The outcome of the screening exercise was reported to the Equality Commission in July 2001.

## DATA COLLECTION AND CONSULTATION

### *Data Collection*

It was decided that any assessment of the equality impacts of the policy should be based on two types of data:

- quantitative data (statistics) which would provide an overview of the background of those GPs who are accredited trainers – and those who are not; likewise of those who currently act as a named supervisor for a GP Retainer, those who are eligible to act in this capacity – and those who belong to neither of these two categories;
- qualitative data which would provide some insights into perceptions held by GPs as the main stakeholders of the two schemes regarding the strengths and weaknesses of the current policies and their practice as well as potential inequalities and suggestions for improvement.

Accordingly, an audit was undertaken to identify available data and means of filling existing data gaps. In sum, data collection was undertaken in the following way:

- ***collection of quantitative data***

At present, the NICPMDE holds some equality data on accredited trainers. This data covers the two dimensions of age and gender. It was decided that a ***survey of all accredited GP trainers and GP Retainer supervisors*** would be conducted to collect data on the dimensions of religion, dependants, marital status, ethnicity, and disability. It was agreed that the categories of sexual orientation and politics would not be surveyed due to their sensitivity. Recent attempts to gather monitoring data on politics in the context of promoting good relations within the organisation had shown a strong reluctance on the side of respondents to reveal their political affiliation.

- ***collection of qualitative data***

In order to explore the views and suggestions of GPs regarding inequalities in relation to all nine categories, an invitation was sent to all GPs (1068 in total) to attend one of two **focus groups** scheduled to be held at night-time in two different locations across Northern Ireland (Belfast and Antrim). Unfortunately, only 6 GPs confirmed their willingness to attend, dates and venues possibly having posed difficulties for further GPs wishing to participate. In order to ensure the most efficient use of available resources, it was therefore decided to cancel the focus groups and opt for a wider approach instead. Accordingly, a brief two-page **questionnaire** was sent to all GPs **based on a set of open-ended questions** (see Appendix 2), thus providing GPs with the opportunity to make their voices heard in writing. In order to ensure complete confidentiality, GPs were not asked to reveal their identity in the survey.

In all, 5 % (56 individuals out of 1068) of all GPs responded to the questionnaire.

### **Consultation**

The draft EQIA report was published for consultation on 29 November 2002. A range of *dissemination methods* were used:

- an ad was placed in the Belfast Telegraph, The Irish News and The Newsletter on 29 November 2002 to announce the beginning of the consultation period;
- the EQIA report was placed on the website of the Agency, both as a summary and the full report;
- an email was sent to 267 consultees (see Appendix 3) on 29 November 2002 comprised of a consultation announcement, a summary report and contact details for the Equality Unit of the Agency;
- the same was sent by post to 30 further consultees (see Appendix 3) who do not have access to the internet or email.

The consultation period lasted for 11 weeks from 29 November 2002 to 14 February 2003. Given the relatively small number of

GPs who had expressed their interest in attending a focus group at the data collection stage of the EQIA, it was decided that consultation meetings would be unlikely to solicit a large response and thus would not constitute the best use of resources. Accordingly, the chosen method focused on soliciting written responses. **Letters were sent out to all GPs in Northern Ireland**, providing them with a summary of the report as well as details on how to access the full report and inviting them to comment on the EQIA. In addition, the NICPMDE approached the British Medical Association to comment on the report.

Finally, a **pro forma** was sent to all organisations on the consultation list, inviting responses to a set of focused questions (see Appendix 4). A total of 13 responses were received. Eight of these stated that they did not wish to make any comments; five provided specific comments.

All comments received in writing and/ or made in the course of the consultation meeting are listed in Appendix 5 together with the response by the Council.

## **KEY FINDINGS**

The EQIA sought to collect data relating to the impact of the policy on the selection of GP Trainers and GP Retainer supervisors across all the nine equality target groups. In a first step, it aimed to cast light on which GPs are trainers, eligible or active supervisors of GP Retainers and which are not, both in terms of their equality background.

### ***Profile of GP Trainers and GP Retainer Supervisors***

The high return rate of questionnaires (in all, 57 individuals or 61% of all accredited GP trainers responded to the survey) means that it is possible to arrive at a fairly reliable picture of the profile of GP Trainers. In the following section, a description of the sample is outlined alongside which a comparison with all GPs (for the categories of age and gender) or (in relation to all other categories) the wider Northern Irish population is placed.

In principle the same applies to eligible and active GP Retainer supervisors even if to a lesser extent. A return rate of 38% for the first (a total of 62 out of 165 GPs) and 43% (a total of 19 out of 44 individuals) for the second of these groups was recorded.

### **Gender**

Nearly 75% of accredited GP Trainers are men, which suggests a highly uneven gender profile. Even when the gender imbalance within the entire GP population is taken into consideration (66% are male), it emerges that women are still under-represented amongst GP Trainers. The same imbalance applies within the group of eligible GP Retainer supervisors. There is an even lower incidence of females among those currently acting a named supervisor which suggest that men are even more likely to be selected by GP Retainers.

### **Age**

The analysis reveals a somewhat uneven age structure amongst GP Trainers, skewed towards the 40-49 year olds who make up 63% of the sample. A comparison with the entire GP population shows that this age group is over-represented amongst GP

Trainers (63% compared to 42%). While it may be argued that the under-representation of the 30-39 age bracket is due to the need for a number of years of experience in the profession in order to fulfil the role as a GP Trainer in a meaningful way, it is difficult to account for the under-representation of other age groups, in particular the 60-69 year olds (2% compared to 5%), other than by disadvantage or self-discrimination.

The same applies to the group of GPs who are eligible to act as GP Retainer supervisors. Interestingly, however, the age composition of supervisors who are currently active shows slightly diverges from the other groups, suggesting that GP Retainers are more likely to pick younger supervisors.

### **Religious Belief**

The survey revealed that a slightly higher share of accredited GP Trainers are Protestant (52%) compared to 39% Catholics (a rather high proportion of respondents – 9% – described their religious affiliation as ‘neither’). While, in the absence of available data, it is impossible to determine whether this mirrors an imbalance within the GP population as a whole, data from the 2001 Labour Force Survey (Equality Commission 2001) suggests that it is closely in line with the structure of the general working population.

While the same circumstances can be observed in relation to the group of GPs who are eligible to act as supervisors for a GP Retainer, the religious composition of those who currently act as supervisors appears to be unevenly distributed: 72% of them are Protestant.

### **Ethnicity**

All GP Trainers as well as eligible and active GP Retainer supervisors indicated that their ethnicity is ‘white’; none belong to any black and minority ethnic group. While this may be considered as highly problematic as such, in the absence of available data it is impossible to determine whether this indicates adverse impacts of the policies or rather constitutes a reflection of a lack of GPs from ethnic minorities in Northern Ireland.

However, data from the Multi Cultural Resource Centre (MCRC) suggests that at the very least some 1.5% of the Northern Irish population belongs to a black and minority ethnic group. It might therefore seem plausible to expect a similar figure amongst the GP population, suggesting in turn that it might be reasonable to expect some members of a black and minority ethnic group amongst GP Trainers and GP Retainer supervisors, even if only a very small number.

### **Marital Status**

There are hardly any single people amongst accredited GP Trainers (a mere 9%); 90% are married. The same applies to eligible and active GP Retainer supervisors. As in relation to some of the other categories it is impossible to draw conclusions as to whether this is an adverse impact of the policies themselves given the lack of comparator data for GPs as a whole. In the case of GP Trainers, it may however be argued that this may be a direct outcome of the skewed age structure in that single people are more likely to belong to younger age brackets which in turn are under-represented amongst GP Trainers.

### **Disability**

Similar to the category of black and minority ethnic group, the analysis reveals that the group of accredited GP Trainers as well as eligible and active GP Retainer supervisors is made up entirely of non-disabled persons. Disabled people are not represented amongst the GP Trainers etc.. Again, in the absence of comparator data for the entire GP population it is impossible to determine whether this indicates an adverse impact of the policy itself or mirrors a lack of representation of disabled people amongst GPs overall.

Estimates based on the Labour Force Survey (Equality Commission 2001) show, however, that 20% of people of working age have a disability. Even if the comparator data is narrowed down to highly qualified people of working age (those with a degree) the share of persons with a disability is still significant (5%). This suggests that it might be reasonable to expect some GPs and therefore GP Trainers to have a disability, in line with other types of occupations.

A note of caution should be taken, however, in interpreting these figures as revealing the complete exclusion of disabled persons amongst GP Trainers. The survey asked individuals to indicate whether they consider themselves to meet the definition as set out in the Disability Discrimination Act. Respondents, however, may be reluctant to either reveal a disability or reject the wording of the definition. Thus, the survey figures may under-record the actual incidence of disability amongst GP Trainers.

## **Dependants**

At present, about 80% of all GP Trainers have dependants. The lack of comparator data for the entire GP population does not allow any definite conclusions as to adverse impacts of the policy to be drawn, however. A similar pattern emerges in relation to both eligible and active GP Retainer supervisors.

## ***GP Evaluation of Current Policy and Practice***

### **Strengths and Weaknesses**

GPs were divided in their assessment of the ***transparency of the schemes*** at present. While a substantial number of respondents explicitly endorsed the two schemes as being open to all GPs who are willing to undergo the process, a significant minority viewed the scheme as lacking in openness. Some argued that too little information was disseminated by the Council, in particular in relation to the GP Retainer scheme. Others pointed out, however, that their own lack of awareness and in-depth knowledge of the process was due more to their lack of interest or need rather than due to any shortcomings on the side of the Council.

A second issue that drew much attention by GPs related to the ***composition of the selection team***. Peer involvement in the selection team was identified as a major strength. One respondent moreover argued in relation to the GP Retainer scheme that the input of trainees themselves in the panel constituted an important strength. Overall, it was thought that the selection team performed its function in a very professional manner.

The ***decision-making process*** was considered fair and clear for the most part. On the other hand, a number of GPs raised

concerns over some components of the process. It was argued, for instance, that the assessment of weaknesses of a practice was by nature subjective and that at times the panel had shown insensitivity to circumstances of individual practices (small ones in particular). Slightly more concerns emerged regarding the GP Retainer scheme. Incidences, albeit only a few, were reported where GPs had either experienced a lack of feedback for decisions taken by the Council on individual applications or perceived the Council to have acted in disregard of its own protocol (an incidence where a GP had been informed by the Council that no places were available in the GP Retainer scheme only to hear of a new appointment in the immediate neighbourhood a short time later).

It was moreover argued in relation to the GP Trainer selection that at times, not enough weight was placed on a GP's social skills, skills in dealing with patients being given too little weight vis-à-vis medical/ training skills, which was seen to be setting a bad example to trainees.

GPs also drew much attention to positive side-effects of current policy and practice in that the rigorous selection process for GP Trainers **ensures a high standard** of both GP training and ultimately of GP practice.

In relation to the GP Retainer scheme GPs moreover positively assessed the **wider choice of practices for GP Retainers** as well as the fact that GP Retainer practices do not have to go through yet another training process in order to be accredited.

## **Inequalities**

It should be noted that the questionnaire returns raised a range of issues in the context of equality of opportunity, some of which did not explicitly relate to the target groups defined in the equality legislation. It was decided, however, to report on all of these concerns in order to genuinely reflect the context in which questions of fairness/ unfairness in relation to the nine categories were viewed by the respondents.

A number of significant points were raised:

- a number of GPs explicitly questioned the appropriateness and indeed legality of the current

***age limit of 50 years for first selection of GP Trainers***, pointing to its discriminatory effects;

- it was argued that the exclusion of part-time GPs from both schemes means in effect that ***female GPs are discriminated against*** as many of them work on a part-time basis;
- several GPs discerned a ***bias against practices in peripheral, particularly rural areas*** in relation to both schemes; it was argued that regarding the GP Retainer scheme this is due to the fact that Retainers can choose a practice themselves and they are more likely to pick a Belfast-based practice;
- ***small practices are seen to be disadvantaged***, the most obvious manifestations being the direct exclusion of single-handed GPs from the GP Trainer scheme and their indirect exclusion due to inappropriate rules and regulations (such as the stipulation that a GP Retainer must not be left to practice on their own at any time) or the expense incurred in participating in the scheme.

A number of further points were raised by individual GPs:

- at times suitable candidates are disadvantaged by the fact that GPs still depend on their partners for endorsement and, in small practices in particular, on adequate teaching facilities;
- some GPs have been asked to stop delivering training without being given a reason (is this an instance of age discrimination?);
- views diverged on the instance of practices with multiple trainers; some GPs argued that allowing some practices to have more than one trainer may disadvantage smaller practices and thus be unfair; others maintained that practices with more than one trainer are disadvantaged as they cannot train more than one registrar at a time.

## GP Suggestions on How Present Weaknesses and Inequalities May Be Overcome

GPs offered a wide range of suggestions how present weaknesses and inequalities may be addressed:

- Most commonly, GPs suggested that **information on both schemes should be more widely disseminated**. The criteria applied in the process should be published more widely. Ideally, they could be sent out to all practices.
- The Council should consider **introducing a more open and systematic process for GP Retainers**: for example by compiling a list of practices to be distributed amongst all GP Retainer applicants as well as a list of Retainers to be distributed amongst all practices.
- The Council, it was argued, should be pro-active in relation to the groups which might currently be disadvantaged (older age groups, females, GPs from new and smaller practices as well as single-handed GPs). **Disadvantaged groups should be specifically encouraged to apply**. Moreover, practices and GPs with no previous training or Retainer experience should be given greater assistance (such as through advisory visits by the Council or by linking them up with experienced trainers).
- **GP Retainers should be encouraged to choose practices in rural/ peripheral areas**.
- Likewise, the Council should consider **introducing an option for GPs to act as part-time trainers**. This would allow smaller practices/ single-handed GPs as well as female GPs to partake more widely in the scheme. Training could be delivered and GP Retainers accommodated in co-operation between adjacent practices.
- Rules that indirectly discriminate against smaller practices such as **current working**

***arrangements for GP Retainers should be reviewed.***

- Some respondents suggested more drastic measures: introducing a ***quota system*** for disadvantaged groups.
- ***Scrapping the age limit of 50*** for first time selection was deemed to be an important requirement.
- The Council should ***ensure a broad geographical spread*** of GP Trainers and GP Training as well as GP Retainer practices.
- The Council should choose ***more convenient locations for meetings*** and meeting locum costs may encourage smaller, peripheral practices.
- The Council should ***ensure that members of the re-selection panel have an appropriate understanding*** of individual circumstances of smaller practices in particular.
- The Council should consider imposing an ***upper limit on the number of trainers in any given practice***.

Finally, it is just as important to note that a number of potential inequalities that have emerged from the analysis of the quantitative data were not addressed by GPs. These related to the categories of ethnicity, disability and marital status in particular. Likewise, no evidence emerged concerning potential inequalities on the basis of political affiliation or sexual orientation.

## CONCLUSION

### ***Summary and Assessment of Main Findings***

The assessment is based on the analysis of both quantitative and qualitative data. While the response rate to the conducted survey is comparably low (5% of all GPs) and thus caution has to be taken regarding the wider interpretation of the results, the NICPMDE values the feedback provided by those who offered their views.

In the following, the main findings from the research are summarised and assessed.

- Female GPs do not participate evenly in the GP Trainer scheme nor in the GP Retainer Supervisor scheme. GPs argue that this is in large parts due to the exclusion of part-time GPs from the scheme, who are predominately female. *The assessment of these findings suggests a misconception amongst some GPs regarding the eligibility criteria for the two schemes. The Criteria for Selection/ Reselection state that part-time GPs are acceptable to train a full-time Registrar provided they work no less than 19 hours a week in the practice and that within the practice there is either an adviser, another trainer, a course organiser or a senior member of the Department of General Practice, otherwise a part-time trainer may train a part-time Registrar. These criteria are meant to ensure that a trainer is present at all times for the Registrar. The Council has considered the suggestion to facilitate joined training by practices where only one part-time trainer is present; it has concluded that this would not be in the best interest of Registrars.*
- The quantitative analysis clearly underlines that older people are less likely to act as GP Trainers and GP Retainer Supervisors. This conclusion is endorsed by the perception of GPs. *The age limit of 50 specified in the selection criteria for first*

*appointments appears to act as a clear discriminatory barrier. However, self-discrimination may likewise play a role (GPs in older age groups may resign from their function as a trainer or supervisors).*

- Neither persons with a disability nor people from a black and minority ethnic background participate in either of the two schemes. *However, in the absence of comparator data for the GP population as a whole there is no clear evidence of this being due to adverse impacts of the policy itself. It is unlikely that the percentage of either disabled people or people from a black and minority ethnic background is substantially lower amongst trainers and applicants as well as Retainer supervisors than amongst all GPs. In fact, the Council is aware that members of a black and minority ethnic group have participated in both schemes in the past. Any interpretation of quantitative data on disability has to bear in mind the likelihood of under-reporting.*
- Hardly any single people or people without dependants are to be found amongst GP Trainers and GP Retainer Supervisors. In the absence of comparator data, it is impossible to determine whether this is due to adverse impacts of the policy itself. *It is more likely, however, that this reflects the skewed age structure of participants.*
- The comparison between those who are eligible to act as supervisors for GP Retainers and those who are currently acting as supervisors reveals that Retainers are more likely to pick male, young, Protestant GPs as supervisors. *Practices are chosen by Retainers themselves. Given that GP Retainers are usually women who have domestic commitments which prevent them from working full time, they usually choose practices from the pool which are closest to their homes irrespective of other factors.*

- Some GPs perceive a bias against rural and peripheral practices to be at work in relation to both schemes. *For a number of years now, the Council has operated a quota system specifically to ensure that training is fairly spread across the 6 Day release courses held in Altnagelvin, Craigavon, North Down, Broughshane, Antrim and Belfast. In relation to the GP Retainer scheme, the same basic fact has to be taken into account as in relation to the previous point: the fact that Retainers usually choose practices from the pool which are closest to their homes irrespective of other factors.*
- The majority of GPs surveyed explicitly endorsed the two schemes as being open and transparent. A significant minority, however, felt that information on the scheme is not distributed widely enough. *The Council disseminates information on the 'Learning and Teaching' Course as the first step to becoming a trainer to all GPs by means of a flyer.*

### **Action Points**

The assessment suggests differential impacts of the two policies on two of the equality target groups: females and older people. Evidence of adverse effects on disabled GPs as well as GPs from black and minority ethnic groups necessarily remains inconclusive as data on these groups is not available for the GP population as a whole. No evidence emerged regarding adverse impacts depending on marital status, dependants, religious affiliation, political opinion or sexual orientation.

Taking on board the outcome of the research, the Council will undertake the following actions:

- The Council accepts that the age of 50 should no longer be a cut off point for becoming a trainer nor 60 for retirement. The proposal was brought to the General Practice Committee of the NICPMDE on 4<sup>th</sup> February 2003 for discussion. It was decided that the limits would be removed. Moreover,

trainers above the age of 60 would be encouraged to involve a practice partner in training tasks.

- The Council will include a statement on future mailings that NICPMDE is an equal opportunities employer and that applications from female GPs, older GPs, GPs from ethnic minorities and GPs with a disability will be particularly welcome.
- monitoring data on the categories of age, gender, marital status, dependants, disability, ethnicity, and religion will be collected on a regular basis as part of the application process; once collected, this will allow monitoring of both successful and unsuccessful applicants to which the Council commits itself.

### ***Monitoring***

The delivery of specific action points in this Equality Impact Assessment will be monitored on an ongoing basis and the organisation's Annual Review of Progress will contain a report on the EQIA implementation.

The organisation will seek to put in place arrangements for quantitative monitoring in relation to the categories of age, gender, religion, ethnicity, marital status, dependants, and disability on an annual basis.

The organisation does not have any quantitative monitoring arrangements in place in relation to the categories of political opinion and sexual orientation. Options for qualitative monitoring with regard to these categories will likewise be explored in the course of the first quarter of the new financial year, pending also the publication of further advice by the Equality Commission.

The Council commits itself to revising the policies if monitoring shows adverse impacts.

## **APPENDICES**

## ***Appendix 1: The Steps of an EQIA***

- Aims of Policy
- Consideration of Data
- Assessment of Impacts
- Consideration of Measures
- Formal Consultation
- Decision by Public Authority
- Publication of Results of EQIA
- Monitoring of Adverse Impacts

***Appendix 2: Equality of Opportunity – Questionnaire***

**Do you think that the NICPMDE acts fairly in relation to the selection of GP Trainers and GP Retainer Practices?**

*Selection of GP Trainers*

*Selection of GP Retainer Practices*

**What do you think are the main strengths of current arrangements regarding the two schemes?**

*Selection of GP Trainers*

*Selection of GP Retainer Practices*

**What do you think are the main difficulties in relation to these schemes in terms of fairness?**

*Selection of GP Trainers*

*Selection of GP Retainer Practices*

**What do you think the Council could do to promote greater fairness and opportunity in relation to these schemes?**

*Selection of GP Trainers*

*Selection of GP Retainer Practices*

### **Appendix 3: List of Consultees**

<b>Organisation</b>
Action Cancer
Action for Dysphasic Adults
Action Mental Health
Action MS
Afro-Asian Residents' Group
Age Concern
The HIV Support Centre
Alliance Party of Northern Ireland
Altnagelvin HSS Trust
Alzheimers Disease Society
Ark Housing
Armagh and Dungannon HSS Trust
Armagh Travellers Support Group
Arthritis Care
Arts Council NI
ASBAH
ASBAH
Association of Chief Officers of Voluntary Associations (ACOVO)
Association Of Independent Advice Centre NI
Baha'i Community
Banbridge Youth Arts & Information Centre
Baptist Church of Ireland
Barnardos
Belfast Brook Advisory Centre
Belfast Carers Centre
Belfast Chinese Christian Church
Belfast City Hospital Health and Social Services Trust
Belfast Hebrew Congregation
Belfast Institute of Further and Higher Education
Belfast Islamic Centre
Belfast Regeneration Office
Belfast Travellers' Education & Dev. Group
Belfast Travellers Support Group
BIH Housing Association
British Deaf Association (NI)
British Dental Association NI
British Diabetic Association
British Medical Association
British Association of Social Workers (NI Office)
Bryson House
Carafriend
Carer's Northern Ireland
Carrickfergus Borough Council
Castlereagh Borough Council

Catholic Boy Scouts Foundation NI
CAUSE
Causeway HSS Trust
Centre for Voluntary Action Studies
Challenge
Chest, Heart and Stroke Organisation
Child Poverty Action Group
Childcare Northern Ireland
Childline NI
Children's Law Centre NI
Chinese Chamber of Commerce (NI)
Chinese Health Project
Chinese Welfare Association (NI)
Choice Housing Association
Church of Ireland
Coalition on Sexual Orientation
Coleraine Borough Council
Colin Glen Trust
Committee on the Administration of Justice
Community Development and Health Network
Community Practitioners & Health Visitors Association
Community Relations Council
Community Relations Training and Learning Consortium
Community Work Education and Training Network
Confederation of Community Groups
Contact A Family
Cookstown District Council
Council for Ethnic Equality
Council for the Homeless
Craigavon and Banbridge Community HSS Trust
Craigavon Area Hospital Group HSS Trust
Craigavon Asian Women's & Children's Association ( AL-NUR)
Craigavon Borough Council
Craigavon Travellers' Support Committee
Craigavon Vietnamese Group
Crossroads
CRUSE
Cystic Fibrosis Trust
Democratic Unionist Party
Department of Culture, Arts and Leisure
Department of Health, Social Services and Public Safety
Derry City Council
Derry Travellers' Support Group
Derry Well Woman
Disability Action
Division of Clinical Psychology
Down & Connor Family Ministry
Down District Council

Down Lisburn HSS Trust
Down's Syndrome Association
Dungannon & South Tyrone Borough Council
Dunlewey Substance Advice Centre
East Belfast Community Development Agency
Eastern Health and Social Services Board
Eastern Health and Social Services Council
Employer's Forum on Disability
Enterprise House
Equality Forum NI
Equality Unit
Extern
Extra Care
Falls Community Council
Family Planning Association NI
Fermanagh District Council
Fermanagh Women's Network
Filor Housing Association
First Key
Fold Housing Association
Forum For Action On Substance Abuse
Foyle Down's Syndrome Trust
Foyle Friend
Foyle HSS Trust
Free Presbyterian Church
Gay & Lesbian Youth Northern Ireland
Gingerbread Northern Ireland
Glen Road Heights Women's Group, BTSP
Glencraig Camphill Community
Green Park Healthcare Trust
Guide Association NI
Health Action Zone
Health Promotion Agency
Help the Aged
Homefirst Community Trust
Homeless Support Unit
Housing Executive
Housing Rights Service
Include Youth
Indian Community Centre
Industrial Therapy Organisation
Inter Church Millennium Celebration Group
Karen Mortlock Trust
La Societa Italiana Irlanda Del Nord
Larne Borough Council
Law Centre NI
Law Society NI
Lesbian Line

Limavady Borough Council
Lisburn Borough Council
Magherafelt District Council
Magherafelt Women's Group
Manufacturing Science and Finance Union
Mater Infirmorium Health and Social Services Trust
MENCAP
Mental Health Commission for Northern Ireland
Mental Health Review Tribunal
Methodist Church in Ireland
Mind Yourself
Monagh Road Women's Steering Group
Moyle District Council
Multi-Cultural Resource Centre (NI)
Multiple Sclerosis Society
Muscular Dystrophy Group
N.I Association For Mental Health
Rethink
Newry & Mourne District Council
Newry & Mourne Mental Health Forum
Newry & Mourne Senior Citizens' Forum
Newry & Mourne Women
Newry Interagency Consortium for Travellers
Newry Travellers' Early Years Action Group
Newtonabbey Borough Council
Newtownabbey Senior Citizen's Forum
NI Committee of Irish Congress of Trade Unions
NI Council for the Homeless
NI Women's Aid Federation
NIACAB
NIACRO
NICOD
NIPPA
North and West HSS Trust
North Down Borough Council
North West Community Network
North West Ethnic Communities Assoc
North West Forum of People with Disabilities
Northern Health and Social Services Board
Northern Health and Social Services Council
Northern Ireland African Cultural Centre
Northern Ireland Anti Poverty Network
Northern Ireland Council for Ethnic Minorities
Northern Ireland Council for Voluntary Action
Northern Ireland Environmental Link
Northern Ireland Filipino Association
Northern Ireland Filipino Community in Action
Northern Ireland Gay Rights Association
Northern Ireland Human Rights Commission (NIHRC)

Northern Ireland Events Company
Northern Ireland Office
Northern Ireland Partnership Board
Northern Ireland Public Service Alliance
Northern Ireland Statistics and Research Agency (NISRA)
Northern Ireland Voluntary Trust
Northern Ireland Volunteer Development Agency
Northern Ireland Women's Aid Foundation
Northern Ireland Womens European Platform
Northern Ireland Youth Forum
NSPCC
NUS-USI Northern Ireland Student Centre
Office of the First Minister and Deputy First Minister
Oi-Kwan Chinese Women's Group
Omagh District Council
Omagh Women's Area Network
Organisation of the Unemployed
Parents Advice Centre
Parents and Professionals and Autism
Presbyterian Church in Ireland
PHAB (NI)
Playboard
Police Service of Northern Ireland
Praxis
Princes Trust
Prison Service Agency
Probation Board for NI
Progressive House
Prospects for People with Learning Disabilities
Proteus
Putting Children First
Queer Space
Regional Office
Registered Homes Confederation
Registration & Inspection Unit
RELATE N Ireland
RNIB
RNID
Royal College of GPs
Royal College of Midwives
Royal College of Nursing
Rural Community Network
Rural Development Council
Salvation Army
Save the Children
Scouting Association NI
SDLP
Sense NI
Shadow Trust
Shelter
Sikh Culture Centre
Simon Community

Sinn Fein
South and East HSS Trust
South West Belfast Community Forum
Southern Health and Social Services Board
Southern Health and Social Services Council
Southern Travellers' Early Years Partners
Sperrin Lakeland Health and Social Care Trust
Sperrin Lakeland Senior Citizens' Consortium
Staff Commission for Education and Library Boards
Strabane District Council
Sustainable Northern Ireland Programme
The Archbishop of Armagh
The Beeches
The Cedar Foundation
The Guide Dogs for the Blind Association
The Local Government Staff Commission for NI (LGSC)
The Northern Ireland Ambulance Services HSS Trust
The Orchardville Society
The Rainbow Project
The Royal College of Psychiatrists
The Royal Group of Hospitals Trust
The Samaritans
The Women's Centre
Threshold
Training for Women Network
Traveller Movement Northern Ireland
Travellers Support Group for Playgroup Workers
Triangle Housing Association Ltd
Ulster Community and Hospitals Trust
Ulster Peoples College
Ulster Quaker Service Committee
Ulster Unionist Party
UNISON
United Hospitals HSS Trust
U3AFoyle
Victim Support
Voice of Young People in Care (VOYPIC)
Voluntary Activity Unit
Voluntary Service Belfast
WAVE
West Belfast Economic Forum
Western Health and Social Services Board
Western Health and Social Services Council
Women's Information Group
Women's Resource and Development Agency
Women's Support Network
Workers Educational Association
Young Carers Project

Youth Action NI
Youth Council
Youthnet

#### ***Appendix 4: Consultation Pro-Forma***

Do you have any comment on individual findings and their assessment by the organisation?

Are there any further equality issues in relation to the policies which the report does not address?

Do you think that the action proposed by the organisation is appropriate for addressing the issues?

Do you have any further suggestions how the organisation may address the issues identified in the findings?

Would you like to make any further comments?

**Appendix 5: Comments Received During Consultation**

	<i>comments received</i>	<i>response</i>
NI Ombudsman (Assembly Ombudsman for NI; NI Commissioner for Complaints)	no comment	
Armagh and Dungannon HSS Trust	no comment	
Craigavon and Banbridge Community Trust	no comment	
NI Housing Executive	no comment	
Action Mental Health	assessments have been carried out thoroughly and in line with accepted good practice	
Princes Trust	no comment	
NISRA	no comment	
BMA	no comment	

<b>Specific Comments</b>	<b>Comments Received</b>	<b>Response</b>
Disability Action (on consultation methods)	<p>Email is only one method of consultation and care should be taken that it does not become the only way as many s75 groups do not have ICT resources</p> <p>Proposed letters to organisations should include description of policies and narrative on how it could affect all s75 groups.</p> <p>Consultation processes should be carefully monitored to ensure those with a legitimate interest have input.</p>	<p>NICPMDE notes comment and wishes to refer to p.16 regarding the consultation methods used</p> <p>descriptions of policies were included in the documents sent out to consultees but NICPMDE notes and will incorporate the comment on including description in letter itself</p> <p>NICPMDE commits itself to evaluating the consultation process after the completion of the EQIA</p>
Robbie Saulters / DHSSPS	<p>How will all EQIAs be monitored- the system, timeframe and the timetable for what organisations are going to do in respect of them.</p> <p>When final EQIAs are circulated, will they include feed-back received from consultation on them?</p>	<p>see p.29 for monitoring arrangements</p> <p>see this section and cross-references to the text</p>

	<p>Are documents available in other formats?</p> <p>Did organisations consult in other formats?</p>	<p>documents are made available on request</p> <p>NICPMDE did not receive any requests for other formats</p>
<p>Disability Action (on the policies)</p>	<p>DA requests the Council to list the range of accessible formats available (large print, Braille, audio cassette, computer disk etc.) and to remove the wording “positively consider” from this statement as it is the Council’s statutory duty to do so (page 2).</p> <p>DA would query if the survey questions (Appendix 2) were structured in such a way as to elicit qualitative information in relation to the promotion of equality of opportunity and good relations in the context of Section 75 (page 15).</p>	<p>see new paragraph on p.2</p> <p>The survey questions were sent out along with a cover letter explaining about the equality legislation; the questions were shaped by the following considerations:</p> <ul style="list-style-type: none"> <li>• in order to encourage GPs to respond it should be brief and it should link issues of equality to issues of quality regarding the scheme</li> <li>• the questions should be open-ended to gather maximum information</li> <li>• the questions should elicit</li> </ul>

	<p>DA believes that future monitoring is required to gather information to allow consultees to make informed comment <b>and</b> for the Council to meet their statutory duties (page 25).</p> <p>DA would advise the Council that monitoring data on the 9 categories as part of the application process will not entirely meet the Council's statutory duty obligation. The Council must commit to include the monitoring of "successful" applicants as part of the process (page 27).</p> <p>DA is disappointed that the Council does not commit to monitoring the 2 policies for future</p>	<p>information on (1) overall assessment with regard to fairness (2) identify what is working (3) identify problems with regard to inequalities (4) suggestions how to achieve greater equality of opportunity</p> <p>Council agrees with comment; see new section on monitoring on p.29</p> <p>The Council would like to clarify that the action point refers to the data collection which is to take place <i>in the course</i> of the application process; once collected, this will allow monitoring of both successful and unsuccessful applicants to which the Council commits itself (see additional text on p.28).</p> <p>see new section on monitoring on p.29</p>
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	<p>adverse impact.</p> <p>Additionally, the Council does not state that it will revise the policies if monitoring/ evaluation shows greater adverse impact than predicted.</p>	see new section on monitoring on p.29
Dr Janet Willis	disagrees with conclusion regarding single people / people without dependants (page 6)	Council notes the comment
Jim Ferran, Down Lisburn HSS Trust	Notes that no data collected on political affiliation or sexual orientation, however EQIAs stated that " No evidence emerged regarding adverse impacts depending on .... political opinion or sexual orientation". How could evidence emerge if no data is collected on these groups?	The EQIA did not collect any <i>quantitative</i> data on political opinion and sexual orientation; in the survey (i.e. <i>qualitative</i> data collection), participants were asked to comment on inequalities with regard to all nine equality categories yet no concerns were expressed in relation to these two dimensions; hence the conclusion that no evidence emerged (see information added in section on collection of qualitative data on p.16)

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