Equality Impact Assessment

On

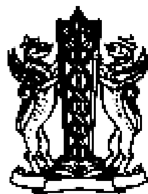
Appointment of Staff to Act on Behalf of the Agency

Specialty Advisers, Training Programme Directors, Tutors, Course Organisers

By

Northern Ireland Medical and Dental Training Agency (NIMDTA)

(formerly the Northern Ireland Council for Postgraduate Medical and Dental Education)



Final Report
September 2004

Executive Summary

This document reports the outcome of an Equality Impact Assessment (EQIA) by the Northern Ireland Medical and Dental Training Agency (NIMDTA) on the 'Appointment of Staff to Act on Behalf of the Agency (Specialty Advisers, Training Programme Directors, Tutors, Course Organisers)'.

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 Medical and Dental Training Agency (NIMDTA) 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 Policy

The aim of the policy is to ensure that the Agency fulfils its functions effectively by drawing on the expertise of a range of further medical and dental professionals, as is the practice in other UK Deaneries. The policy relates to the processes of appointing

such professionals to act on behalf of the Agency in a variety of positions.

Principally, the types of positions involved are: Specialty Advisers, Training Programme Directors, Clinical Tutors, GP Course Organisers, GP Tutors, Hospital Dentistry Advisers, Community Dental Advisers, and Advisers in General Dental Practice.

The terms and conditions of positions differ substantially between specialties. There are two main causes of variation: (1) the size and nature of specialties determining differences in the volume of work involved in a position and (2) historical reasons in the way different specialties and their relationship to the Agency has evolved. Terms and conditions vary mainly with respect to remuneration practices and the duration of contract.

There is also variation in the arrangements for appointing staff to act on behalf of the Agency from one specialty to another. Two main methods can be distinguished: open competition and nomination.

Given that the Specialty Training Committees play a key role in the selection of staff to act on behalf of the Agency when it comes to positions in the hospital specialties, it is their membership and constitution which needs to be considered as well.

The constitution of the Committees, while varying in detail, has common elements across the different specialties. Membership is principally based on representation of key stakeholders. In addition to the Specialty Adviser, representation would normally include trainees and the NIMDTA. The third group of stakeholders – the consultants – are represented either on a hospital, HPSS board or sub-specialty basis.

The method by which trainee and consultant representatives become members is arguably of key importance. Here again, the arrangements for gaining membership to Committees differ between specialties.

Screening

The policy 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 assessing 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 policy.

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

Data Collection and Consultation

Firstly, the Agency conducted a quantitative survey of all staff acting on its behalf and all members of Specialty Training Committees as the pool from which most individuals are appointed. The survey collected data on age, gender, religion, dependants, marital status, ethnicity, and disability.

Secondly, a questionnaire was sent to all consultants, GDPs and GPs providing them with the opportunity to express their views and suggestions on equality of opportunity regarding positions and Committee membership. Participants were asked to share their views on inequalities, potential barriers and ways of addressing these with regards to all nine Section 75 groups.

Thirdly, the NIMDTA approached the British Medical Association and the British Dental Association for one-to-one interviews.

The consultation period lasted for 12 weeks from 19 December 2003 to 12 March 2004. Given the Agency’s experience of conducting consultation on previous EQIAs, in which relatively small numbers of medical and dental practitioners had expressed their interest in attending focus groups, 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 methods focused on (1) soliciting written responses and (2) engaging with professional organisations. Letters were sent out to all consultants, GPs and GDPs 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. Moreover, a pro forma was sent to all organisations on the consultation list, inviting responses to a set of focused questions. The NIMDTA approached the British Medical Association (BMA) and British Dental Association (BDA) for comments on the report. Moreover, a presentation was given at one of the BDA's Council meetings. A total of 11 responses were received.

Key Findings

Response rates to the quantitative questionnaire were excellent (78.5%), providing for a high accuracy of the profile of post holders and Committee members in relation to Section 75 groups. The response rate to the qualitative survey of GPs and GDPs was comparably low (6.2% and 7.8% respectively – vis-à-vis 23.5% for consultants), and thus caution is required regarding the wider interpretation of these particular results. The NIMDTA does value the feedback provided by those who offered their views.

The assessment suggests differential impacts of the policy on a number of the equality target groups: females, younger people, Catholics, single people and people without dependants. Evidence of adverse effects on disabled medical and dental practitioners as well as medical and dental practitioners from black and minority ethnic groups remains inconclusive as data on these groups is not available for the respective population as a whole. No evidence emerged from the qualitative survey regarding adverse impacts depending on political opinion or sexual orientation.

- The participation of women in the allocation of positions is low; they are under-represented taking account of their share within the population of practitioners in Northern Ireland as a whole. This is particularly stark in relation to the GDP positions. Differentials are much smaller with regards to the other two Agency departments.

- The quantitative analysis clearly shows that younger people (under the age of 40) are disadvantaged regarding access to positions and Committee membership. This applies in particular to positions in the hospital specialties and Dentistry. This conclusion is endorsed by the perception of survey participants.

- A comparison of the sample with Census data seems to suggest that Catholics have unequal access to positions and Committee membership. In the absence of available data, it is however impossible to determine whether this mirrors imbalances within the entire population of medical and dental practitioners in Northern Ireland. The imbalance is particularly pronounced in relation to positions in the Dental department.

- The survey reveals a limited ethnic diversity amongst those holding Agency positions. In the absence of comparator data for the population of medical and dental practitioners as a whole, it is impossible to determine whether this indicates adverse impacts of the policy or reflects a lack of ethnic diversity amongst the respective professionals in Northern Ireland. The lack of diversity amongst GP and GDP post holders, however, should be kept under review.

- Single people and people without young dependants do not appear to have equal access to positions and Committees. This is likely to reflect the skewed age structure of participants.

- There are indications that medical and dental practitioners with a disability may be under-represented amongst position holders and Committee members.

- Beyond the nine groups, inequalities are perceived by some doctors in relation to geography, people from outside Belfast being disadvantaged due to the choice of venue of meetings. Concerns were also raised by individuals with regards to the size of a hospital/ practice, part-time staff, non-QUB graduates and GDPs without postgraduate qualifications.

The great majority of participants of the survey as well as the BMA representative expressed their concern that in many cases appointments lack transparency and openness. Considering current arrangements the concern appears to be well founded in particular with regards to the hospital specialties. The lack of open competition for positions is of concern as are shortcomings with regards to the dissemination of information on appointment procedures, vacancies arising, job descriptions and selection

criteria, all of which are fundamental to ensure equality of opportunity. The permanent nature of positions further fuels perceptions of a ‘closed shop’, i.e. of an exclusive network.

Action Points

Taking on board the outcome of the research, the Agency commits itself to undertaking the following actions:

(1) The Agency will seek to widen the application of its existing appointment procedures and practices to ensure an open, transparent and consistent appointment process across all positions and specialties, taking account of the particular circumstances of smaller specialties. The Agency will make those exceptional circumstances public.

(2) The Agency will recruit on a fixed-term basis where it is considered to be appropriate (in the case of the recent recruitment of a Chief Executive, for example, this was not considered appropriate).

(3) The Agency will ensure that documentation is available for all positions regarding:
a) job descriptions
b) personnel specifications
c) terms and conditions (including the number of sessions).
This will be undertaken in consultation with the Royal Colleges, the BMA and the BDA. Particular emphasis will be given to examining the equality impacts of any of these, in particular in relation to the groups currently under-represented. The Agency commits itself to applying new guidance on ‘The 5 C’s of Information Provision’ in all their applications.

(4) In putting together interview panels, the Agency will encourage individuals from under-represented groups to become involved.

(5) The Agency will draft a communication strategy, i.e. a policy on the dissemination of information, outlining procedures for advertising positions (e.g. through HPSS-wide job trawls) and disseminating written information on positions (i.e. job descriptions, personnel specifications, terms and conditions) to all existing and new doctors.

(6) The Agency will seek to produce a Code of Practice for the appointment of medical and dental practitioners to become members of Specialty Training Committees.

(7) The Agency will encourage Committees to explore the viability of introducing the use of videoconferencing facilities and rotating the venue of meetings. Agency will provide Committees with advice and guidance on range of locations and venues available, esp. outside of Belfast. Agency will encourage Committees varying meeting times and considering availability of childcare wherever possible.

(8) Equality data on seven of the nine groups will be collected at the application stage in order to allow for ongoing monitoring in compliance with provisions under the Data Protection Act.

(9) Summary monitoring data will be published on an annual basis to provide greater transparency as to applicants and appointees.

(10) The Agency will include a statement in future advertisements that NIMDTA is an equal opportunities employer (spelling out all nine groups) and that applications from the under-represented groups will be particularly welcome.

(11) The Agency will seek to further develop its engagement with organisations representing the interests of Section 75 groups, in particular with regards to exploring potential barriers and ways of addressing them.

(12) The Agency will introduce both equality awareness training and induction training for those working on its behalf; it will also distribute information materials on equality to staff.

(13) The Agency will continue to lobby the DHSSPS for supporting the collection of quantitative monitoring data on all GPs, GDPs and hospital consultants.

Monitoring

Within the course of the third quarter of 2004-2005, a delivery plan will be drawn up to implement specific action points emanating from the assessment. 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, pending also the publication of further advice by the Equality Commission.

The Agency commits itself to revising the policy if monitoring shows adverse impacts.

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1 BACKGROUND

1.1 Organisational Background

The Northern Ireland Medical and Dental Training Agency (NIMDTA) 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 Agency, 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 Agency 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 Agency. Thirty-five members of staff are based at Agency Headquarters.

1.2 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 explained in Appendix 1.

1.3 The Policy on the Appointment of Staff to Act on Behalf of the Agency (Specialty Advisers, Training Programme Directors, Tutors, Course Organisers)

The aim of the policy is to ensure that the Agency fulfils its functions effectively by drawing on the expertise of a range of further medical and dental professionals, as is the practice in other UK Deaneries. The policy relates to the processes of appointing such professionals to act on behalf of the Agency in a variety of positions.

what do professionals acting on behalf of the Agency do?

Principally, the types of positions involved are:

- Hospital Specialty Advisers
  Their roles vary depending on the specialty but often include managing education and training and the vetting of proposed consultant posts.

- Training Programme Directors
  They manage the delivery of the programme of specialist training (the training phase which follows the general professional training/ basic specialist training of a doctor).

- Clinical Tutors
  Their role is to manage a Trust's postgraduate or education centre and the study leave budget for the Trust.

- GP Course Organisers
  They are responsible for the local vocational training scheme (the training phase which follows the general professional training/ basic specialist training of a GP).

- GP Tutors
  Their role is to assist in the continuing professional development of GPs in Northern Ireland.

- Hospital Dentistry Advisers
  They oversee the provision of training for Junior Hospital dental staff.

- Community Dental Advisers
  Their role is to provide career guidance and develop continuing professional education for community dentists.

- Advisers in General Dental Practice
  These include VT Advisers, GPT Advisers and Continuing Education Advisers/Tutors. These roles vary in that VT/GPT Advisers have the responsibility to organise and monitor Vocational Training and General Professional Training in Northern Ireland; Continuing Education Advisers/Tutors are responsible for the organisation of a programme of continuing professional education for dentists in Northern Ireland; and Study Club Tutors have a responsibility for providing a forum for those who are pursuing further training and examinations pertinent to General Dental Practice and a framework for reflective learning.

The terms and conditions of positions differ substantially between specialties. There are two main causes of variation: (1) the size and nature of specialties determining differences in the volume of work involved in a position and (2) historical reasons in the way different specialties and their relationship to the Agency has evolved. Terms and conditions vary mainly with respect to remuneration practices and the duration of contract.

how are individuals appointed to positions?

There is also variation in the arrangements for appointing staff to act on behalf of the Agency from one specialty to another. Two main methods can be distinguished:

- open competition

The Agency directly recruits staff for most positions in the fields of General Practice and Dentistry. This recruitment process is guided

by the Agency's selection and recruitment policy, which in turn is shaped by the Equality Commission's Code of Practice. It includes equal opportunities monitoring.

- nomination

In the hospital specialties, the positions are filled by nominations, which are brought forward by the Specialty Training Committees (STCs). In the case of clinical tutors it is the Trusts who nominate a consultant to fulfil this role, usually following an internal trawl.

how do individuals become members of Specialty Training Committees?

Given that the Specialty Training Committees thus play a key role in the selection of staff to act on behalf of the Agency when it comes to positions in the hospital specialties, it is their membership and constitution which needs to be considered as well.

The constitution of the Committees, while varying in detail, has common elements across the different specialties. Membership is principally based on representation of key stakeholders. In addition to the Specialty Adviser, representation would normally include trainees and the NIMDTA. The third group of stakeholders – the consultants – are represented either on a hospital, HPSS board or sub-specialty basis.

It is the way by which trainee and consultant representatives become members which arguably is of key importance. Here again, the arrangements for gaining membership to Committees differ between specialties.

In sum, therefore, the arrangements for gaining membership to Specialty Training Committees have to date been determined by Committees themselves.

1.4 Screening

The policy 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 policy.

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

2 DATA COLLECTION AND CONSULTATION

2.1 Data Collection

An audit was undertaken to identify available data and means of filling existing data gaps. In determining the most appropriate data collection methods, the experience gained from past EQIAs was taken into consideration. In sum, data collection relied on three main methods:

(1) a quantitative survey

All staff acting on behalf of the Agency and all members of Specialty Training Committees – as the main pool from which they are currently recruited – received a tick-box questionnaire to survey their gender, age, marital status, dependants, religion, ethnicity, and disability (see Appendix 2).

The categories of sexual orientation and politics were not surveyed quantitatively 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. This renders any quantitative measuring of the category highly inaccurate, leading the Agency to conclude that any quantitative results would not be reliable nor in fact meaningful.

With regards to sexual orientation, concerns around sensitivity and confidentiality are just as important, as acknowledged by the Equality Commission (2001a, p.13). The Agency participated in the consultation exercise on 'Monitoring for Section 75' undertaken by the Equality Commission during 2002, and awaits the outcome of this consultation. At present, the Agency would be concerned that posing a question on sexual orientation in a quantitative questionnaire would likewise not produce reliable nor meaningful results.

Hence, the Agency decided to employ qualitative methods to explore issues around sexual orientation and political affiliation (see below).

Overall, 78.5% (91 out of 116) of staff acting on behalf of the Agency returned their questionnaires, which constitutes an

excellent response rate. Therefore, the survey allows arriving at a fairly accurate picture of those in post.

The same applies in principle to Committee members even though the response rate is slightly lower, amounting to 63.7% (216 out of 339 individuals).

(2) a qualitative survey

A brief questionnaire was sent to all consultants, GPs and GDPs in Northern Ireland (2693 individuals in total) based on a set of open-ended questions (see Appendix 3). It sought to explore their views regarding inequalities in relation to the policy and suggestions how they can be addressed. Importantly, participants were asked to comment on perceived inequalities, barriers, and suggestions regarding all nine Section 75 groups. In order to ensure complete confidentiality, respondents were not asked to reveal their identity in the survey.

Overall, 12.6% (340 out of 2693) of all recipients responded to the questionnaire, with return rates being highest amongst consultants (23.5%) followed by dentists (7.8%) and GPs (6.2%).

(3) interviews with representatives from the professional organisations

An interview was conducted with a representative from the British Medical Association (BMA) in which key issues in relation to the policy were explored. The British Dental Association (BDA) opted for providing its input during the consultation phase.

2.2 Consultation

The draft EQIA report was published for consultation on 19 December 2003. A range of dissemination methods were used:

- an ad was placed in the Belfast Telegraph, The Irish News and The Newsletter on 19 December 2003 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 over 250 consultees (see Appendix 6) in January 2004 comprised of a consultation announcement, a summary report and contact details for the Equality Manager of the Agency;
- the same was sent by post to 30 further consultees (see Appendix 6) who do not have access to the internet or email.

The consultation period lasted for 12 weeks from 19 December 2003 to 12 March 2004. Given the Agency's experience of conducting consultation on previous EQIAs, in which relatively small numbers of medical and dental practitioners had expressed their interest in attending focus groups, 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 methods focused on:

(1) soliciting written responses

Letters were sent out to all consultants, GPs and GDPs 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.

Moreover, a pro forma was sent to all organisations on the consultation list, inviting responses to a set of focused questions (see Appendix 5).

(2) engaging with professional organisations

The NIMDTA approached the British Medical Association (BMA) and British Dental Association (BDA) for comments on the report. Moreover, a presentation was given at one of the BDA's Council meetings.

A total of 11 responses were received. All comments received are listed in Appendix 7 together with the response by the Agency.

3 KEY FINDINGS

The EQIA sought to collect data relating to the impact of the policy across all the nine equality target groups. In the first section, perceptions of inequalities in relation to the nine categories are reported and a description of the quantitative sample given alongside comparator data (please refer to Appendix 4 for the respective tables). Principally, two comparators were employed:

(1) total GP, GDP and Hospital Consultant populations (DHSSPS data and CSA data for 2001) – available only for the categories of age and gender

(2) the wider Northern Irish population in the age bracket between 25 and 64 years (calculated on the basis of Census 2001 data) – in relation to all other categories.

In the second part, perceptions of practitioners and the BMA representative regarding further inequalities are reported. Subsequently, perceptions of barriers are recounted. Finally, suggestions raised by participants of the research are summarised.

3.1 Assessing the Impacts of the Policy on Section 75 Groups

Gender

A number of respondents pointed to perceived disadvantages for women in accessing positions. The quantitative analysis in fact reveals that nearly 76% of post holders and 72% of Committee members are men, which suggests a highly uneven gender profile. A comparison with the figure for the entire population of medical and dental practitioners in Northern Ireland (69%) shows that men are over-represented amongst post holders but only slightly so amongst Committee members.

The gender imbalance is particularly stark within the Hospital Specialties where over 82% of Agency positions are filled by men. Although the comparator data reveals that this largely reflects the make up of the entire population of consultants, men are still over-represented by 4%. Overall, imbalances vary substantially between specialties.

Strong imbalances exist in relation to GDPs where nearly 78% of post holders are men, which strongly exceeds their share amongst all GDPs (61%). In contrast, the male proportion amongst Committee members is broadly in line with the GDP population.

The situation is remarkably different in relation to GPs. For one, the share of males is lower amongst holders of GP posts (61.5%) than the other two departments and, secondly, females are somewhat over-represented in positions in comparison to their share of the entire GP population (by 5.5%).

Age

The analysis reveals an uneven age structure amongst post holders, skewed in particular towards 40-49 year olds who make up 52.4% of the sample; only 13.1% were under the age of 40.

The imbalance is somewhat smaller amongst post holders of the GP department where under-40-year-olds make up 20%.

A comparison with the entire population of medical and dental practitioners shows that under-40-year-olds are noticeably under-represented (by 21.5%). By comparison, the 40-49 age group is strongly over-represented amongst post holders (52.4% compared to 38.4%) as are 55-59 year olds (22.6% vs. 9.7%).

The under-representation of younger age groups is particularly high in relation to posts in the Dentistry department (by nearly 50%!) and the hospital specialties (by 14.2%).

Similar patterns emerge with regards to Committee membership as a whole. Here, however, the variation between the three departments regarding the share of under-40-year-olds is considerable (ranging from 10.5% in the hospital specialties to 33.4% in Dentistry). The higher share of young practitioners within Dentistry Committees can be ascribed to arrangements being in place by which newly registered GDPs (those under 5 years of registration) are defined as a separate stakeholder. Thus a certain number of places on Committees are ring-fenced for them.

These findings thus endorse concerns raised by participants of the survey regarding a perceived disadvantage on the basis of age. It was thought that a perceived lack of experience of younger

doctors worked to their disadvantage regarding access to positions.

Religious Belief

The survey revealed that a substantially higher share of post holders are Protestant (61.8%) than Catholic (31.5%), with 6.7% of respondents describing their religious affiliation as ‘neither’. The share of the latter is remarkably smaller than in the 2001 Census where it made up 14.5%.

While, in the absence of available data, it is impossible to determine whether this mirrors imbalances within the entire population of medical and dental practitioners in Northern Ireland, data from the 2001 Census suggest that Protestants are over-represented by some 11.5%.

Similar circumstances apply to the Committees where Protestants are over-represented by about 10%.

While the religious/ community composition of post holders in the Hospital and the GP departments are fairly similar (36% Catholics and 64% Protestants), the imbalance is substantially greater in relation to GDP positions, where 87.5% are Protestants.

With regards to Committee membership the size of the imbalance does not vary substantially between the three departments.

The findings from the analysis of quantitative data thus seems to endorse a perception, raised by a number of respondents, of inequalities of access to positions and Committee membership for Catholics.

Ethnicity

A number of respondents perceived medical and dental practitioners from black and minority ethnic groups to experience inequalities of access. The quantitative data reveals that very little diversity exists in relation to the ethnic origin of post holders; only 1.1% belong to black and minority ethnic groups. In the absence of comparator data for the population of medical and dental practitioners as a whole, it is impossible to determine whether this indicates adverse impacts of the policy or reflects a lack of ethnic diversity amongst the respective professionals in Northern Ireland.

The 2001 Census indicated that 0.81% of the population in Northern Ireland belong to a black and minority ethnic group, although some organisations – such as the Multi-Cultural Resource Centre (MCRC) – have disputed this assessment estimating that the proportion of the population is 1.5%.

More importantly, the Census reveals that people from black and minority ethnic groups make up 2.75% of highly qualified people in Northern Ireland (those with level 5 qualifications). It is thus reasonable to assume that the overall share of black and minority ethnic doctors is higher than 1.1%.

Particular concerns emerge in relation to GP and GDP positions where all respondents indicated that their ethnicity is ‘white’; none belong to any black and minority ethnic group.

Interestingly, a somewhat different picture emerges in relation to Committees where about 4.2% of members belong to black and minority ethnic groups. This applies to the hospital specialties in particular. In contrast, again all members of Dentistry Committees are white.

Marital Status

Married people strongly dominate the make up of post holders and committee members (89%). The comparison with Census data shows that they are strongly over-represented (by 15.3%). It is single people who are under-represented in particular (by 17.3% regarding Agency positions and by 15% regarding Committee members).

The imbalance is marked amongst post holders in the GP department all of whom are married.

It may however be argued that this is likely to 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 post holders.

Disability

The survey data shows a certain degree of participation by medical and dental practitioners with a disability in the part-time Agency posts (2.2%) as well as in the Committees (2.8%).

Data from the 2001 Census indicates that 20.6% of people in the respective age group have a limiting long-term illness. 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%) (Equality Commission 2001b). This suggests that medical and dental practitioners with a disability are under-represented amongst post holders and Committee members.

Differences can be noted between the figures for the three departments: the proportion varies between 3.8% (GPs), 1.8% (Hospital Specialties) and 0% (GDPs). The variation is more pronounced in relation to Committee membership, ranging from 7.7% amongst GP to again 0% in Dentistry Committees.

A note of caution should be taken, however, in any interpretation of these figures. 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 post holders and Committee members.

The qualitative survey revealed that a number of respondents have concerns over barriers which people with a disability may face in relation to accessing positions.

Dependants

At present, about 17% of all post holders (and 18.5% of Committee members) take on a carer role for disabled and/or elderly dependants. The lack of comparator data for the entire population of medical and dental practitioners does not allow any definite conclusions to be drawn as to adverse impacts of the policy. However, it seems reasonable to assume that their share is not dissimilar to the Census figures, with which the Agency data is precisely in line (both in relation to post holders and Committee members).

Interestingly, while figures for post holders in the GP department and the Hospital Specialties are largely in line with the overall figure, a substantially greater share of post holders in Dentistry

departments fulfil the role of a carer (25%). The same variation applies with regards to Committee members.

About 68% of post holders and Committee members have dependant children with figures being higher in relation to the GP department (73%/74%) and considerably lower for the Dentistry department (55.6%/62.5%).

Interestingly, all figures are significantly higher than the Northern Irish average (49.3%). These findings are at odds with perceptions widespread amongst participants of the survey that people with dependants are at a disadvantage in accessing positions and Committee membership.

Political Opinion and Sexual Orientation

Finally, it is just as important to note that a number of potential inequalities were not addressed by respondents of the qualitative questionnaire (with the exception of one individual respondent). These related to the categories of political affiliation and sexual orientation.

3.2 Perceived Other Inequalities

Respondents identified a range of further issues in the context of equality of opportunity, which reach beyond the nine groups defined in the equality legislation. In order to genuinely reflect the context in which questions of fairness/ unfairness in relation to the nine categories were viewed by the respondents it is deemed important to report these likewise. Unless stated otherwise comments relate to both positions and Committee membership. Perceptions of further inequalities beyond the nine groups defined in Section 75 related to:

- geography

This issue received substantial attention by consultants and GPs. It was thought that medical and dental practitioners working in hospitals and practices outside Belfast (in rural areas and West of the Bann in particular) had less access to positions and Committee membership. Long travel distances were seen to pose an important barrier as meetings normally took place in Belfast.

- size of hospitals

Amongst consultants, several respondents perceived medical practitioners from smaller hospitals to be at a disadvantage, likewise those working in posts not connected to any academic departments.

- non QUB graduates and people returning to Northern Ireland

Medical and dental practitioners who attended universities outside Northern Ireland were seen by some consultants and GDPs to have less access to positions and Committee membership, partly due to a perception of not being part of and/or not having access to Northern Irish ‘networks’.

- part-time staff

A few respondents likewise raised concerns regarding access issues for part-time staff.

- people in small partnerships

A couple of GPs pointed to difficulties for doctors from small partnerships to partake in these activities, mainly due to problems in finding cover for the times away from the practice on Agency business.

- lack of postgraduate qualifications

A few respondents also considered those without postgraduate qualification to be at a disadvantage in accessing positions and Committee membership.

Further concerns of individual respondents related to non RCGP members (in the case of GPs) and non hospital consultants, non BDA members and non LDC members in the case of GDPs as being disadvantaged.

3.3 Perceived General Barriers

The particular barriers identified in relation to Section 75 groups and those listed above are seen by medical and dental practitioners to be working alongside general barriers. It is these general access barriers that drew by far the most comments by respondents. There was consensus between barriers identified by participants of the survey and the BMA representative.

A perceived lack of transparency and openness in relation to appointments was a primary concern. Respondents explicitly cited the following barriers:

- a lack of publication of information on:
    - a) vacancies arising
    - b) job descriptions
    - c) appointment procedures
    - d) selection criteria

These perceptions were underlined by the fact that overall levels of awareness amongst Consultants, GPs and GDPs regarding current arrangements for appointment were low.

- a lack of open competition for posts

In the case of consultants, respondents identified the fact that names have to be proposed by others as a fundamental barrier. Hence it was thought that one needed to know or be known by 'the right people' in order to attain positions and Committee membership.

- the permanent/ long-term nature of the posts and small number of positions

The permanent nature of the positions was identified as a third key barrier by several respondents, which meant few overall openings. The importance of this factor was re-enforced by the representative of the BMA.

As a result of these various factors (the BMA representative also pointed to appointment practices of Royal Colleges as playing an important role), an exclusive group of consultants were seen to hold the 'reigns of power' in relation to appointments. The terms 'old boys network', 'closed shop', 'secretive', 'elitist' were frequently used, as were the impression of 'not being part of the appropriate circles' and 'not being in the know' as working to one's disadvantage.

In addition, a lack of experience in training was identified by several respondents as posing an important barrier.

It should be emphasised that, in the case of GPs and consultants, time constraints and clinical/ practice workloads (alongside the restricted availability of locums) were likewise seen as an

important obstacle to being more active in relation to posts and training committees. Similarly, a number of GPs and GDPs pointed to concerns over a loss of income resulting from involvement in Committee or Agency work as a barrier. Furthermore, a number of respondents saw a basic lack of interest in becoming involved in Agency work as an important factor.

Finally, it must be taken note that some respondents – even if relatively few – explicitly ascribed a fairness record to the Agency in relation to the recruitment of staff acting on their behalf.

3.4 Suggestions

Survey participants as well as the BMA representative offered a range of suggestions on how the Agency could promote greater fairness and openness in relation to positions and committee membership. Herein, by far the greatest attention was given to suggestions for improving the transparency and openness of the appointment process and raising awareness amongst doctors. The following proposals were brought forward:

- provision of information

Many respondents suggested that information should be disseminated to all medical and dental practitioners via mail shots, flyers, bulletins, email and the internet on (1) the positions (i.e. vacancies arising, job descriptions, terms and conditions) (2) the selection criteria (3) names of current post holders and Committee members and (4) the role of the Agency. The BMA representative emphasised that the Royal Colleges should likewise provide greater transparency regarding selection criteria for the appointment of Regional Advisers.

- monitoring

In a similar vein, it was suggested that membership of committees and positions should be closely monitored and data should be published on a regular basis.

- introducing open competition for positions, involving the public advertisement of vacancies and conducting interviews

Given the current practice of filling positions in the hospital specialties by nominations, consultants and the BMA representative placed much emphasis on the need to introduce direct recruitment, based on the public advertisement of positions. Likewise, the need to ensure that interview panels include members of groups currently underrepresented was underlined. It was thought, moreover, that the appointment of committee members should be monitored externally.

- ensure a wider geographical representation

It was suggested that (1) the venues of meetings should be rotated across Northern Ireland and (2) videoconferencing facilities should be used more widely.

- introducing fixed-term positions and committee membership

Consultants and GDPs in particular argued that the type of contract for positions and Committee membership should be changed from permanent to fixed-term in order to provide more opportunities. This suggestion was supported likewise by the BMA representative.

- targeting underrepresented groups

A number of respondents suggested actively encouraging more people from underrepresented groups, areas and work places to apply for positions. There was disagreement amongst doctors, however, regarding the desirability of positive discrimination measures and quota setting.

- pay for GP positions to reflect true costs of obtaining locum cover and Trusts as employers to make time available for medical practitioners to take up Agency positions

In order to address some of the time constraints reportedly experienced by some GPs, a few respondents suggested that pay should reflect true costs. It was also thought that the timing of meetings should be reviewed. A few consultants proposed a greater recognition on the side of Trusts as employers of the need to make more time available for medical practitioners to act on behalf of the Agency.

- offer training for those without previous experience

In order to widen access, some respondents proposed the provision of training for those interested in becoming involved in the Committees and in taking up positions.

Furthermore, the BMA representative as well as various consultants and GDPs suggested that along with making the appointment processes more transparent and robust, performance management processes should be strengthened to increase accountability. This could be undertaken by means of (1) establishing a Code of Practice (2) regular, meaningful performance reviews of those in post involving input by trainees and (3) co-opting members of professional organisations onto all committees, recognising however that this will require additional resources both for Trusts and the Agency as employers.

Finally, the BMA representative suggested that greater consistency across the specialties should be sought in relation to procedures and practices. He also underlined that meaningful changes in relation to the policy would require a concerted approach, involving all the main players including the Royal Colleges, Trusts and the DHSSPS.

4 CONCLUSION

4.1 Summary and Assessment of Main Findings

In the following, the main findings from the research are summarised and assessed. The assessment is based on the analysis of both quantitative and qualitative data.

Response rates to the quantitative questionnaire were excellent, providing for a high accuracy of the profile of post holders and Committee members in relation to Section 75 groups. The response rate to the qualitative survey of GPs and GDPs was comparably low (6.2% and 7.8% respectively), and thus caution has to be taken regarding the wider interpretation of the results The NIMDTA does value the feedback provided by those who offered their views.

The assessment suggests differential impacts of the policy on a number of the equality target groups: females, younger people, Catholics, single people and people without dependants. Evidence of adverse effects on disabled doctors as well as doctors from black and minority ethnic groups necessarily remains inconclusive as data on these groups is not available for the respective population as a whole. No evidence emerged regarding adverse impacts depending on political opinion or sexual orientation.

- The participation of women in the allocation of positions is low; they are under-represented taking account of their share within the population of practitioners in Northern Ireland as a whole. This is particularly stark in relation to the GDP positions. Differentials are much smaller with regards to the other two Agency departments.

- The quantitative analysis clearly shows that younger people (under the age of 40) are disadvantaged regarding access to positions and Committee membership. This applies in particular to positions in the hospital specialties and Dentistry. This conclusion is endorsed by the perception of survey participants.

- A comparison of the sample with Census data seems to suggest that Catholics have unequal access to positions and Committee membership. In the absence of available

data, it is however impossible to determine whether this mirrors imbalances within the entire population of medical and dental practitioners in Northern Ireland. The imbalance is particularly pronounced in relation to positions in the Dental department.

- The survey reveals a limited ethnic diversity amongst those holding Agency positions. In the absence of comparator data for the population of medical and dental practitioners as a whole, it is impossible to determine whether this indicates adverse impacts of the policy or reflects a lack of ethnic diversity amongst the respective professionals in Northern Ireland. The lack of diversity amongst GP and GDP post holders, however, should be kept under review.
- Single people and people without young dependants do not appear to have equal access to positions and Committees. This is likely to reflect the skewed age structure of participants.
- There are indications that medical and dental practitioners with a disability may be under-represented amongst position holders and Committee members.
- Beyond the nine groups, inequalities are perceived by some doctors in relation to geography, people from outside Belfast being disadvantaged due to the choice of venue of meetings. Concerns were also raised by individuals with regards to the size of a hospital/ practice, part-time staff, non-QUB graduates and GDPs without postgraduate qualifications.

The great majority of participants of the survey as well as the BMA representative expressed their concern that in many cases appointments lack transparency and openness. Considering current arrangements the concern appears to be well founded in particular with regards to the hospital specialties. The lack of open competition for positions is of concern as are shortcomings with regards to the dissemination of information on appointment procedures, vacancies arising, job descriptions and selection criteria, all of which are fundamental to ensure equality of opportunity. The permanent nature of positions further fuels perceptions of a ‘closed shop’, i.e. of an exclusive network.

4.2 Action Points

Taking on board the outcome of the research, the Agency commits itself to undertaking the following actions:

(1) The Agency will seek to widen the application of its existing appointment procedures and practices to ensure an open, transparent and consistent appointment process across <u>all</u> positions and specialties, taking account of the particular circumstances of smaller specialties. The Agency will make those exceptional circumstances public.

(2) The Agency will recruit on a fixed-term basis where it is considered to be appropriate (in the case of the recent recruitment of a Chief Executive, for example, this was not considered appropriate).

(3) The Agency will ensure that documentation is available for all positions regarding:
a) job descriptions
b) personnel specifications
c) terms and conditions (including the number of sessions).
This will be undertaken in consultation with the Royal Colleges, the BMA and the BDA. Particular emphasis will be given to examining the equality impacts of any of these, in particular in relation to the groups currently under-represented. The Agency commits itself to applying new guidance on ‘The 5 C’s of Information Provision’ in all their applications.

(4) In putting together interview panels, the Agency will encourage individuals from under-represented groups to become involved.

(5) The Agency will draft a communication strategy, i.e. a policy on the dissemination of information, outlining procedures for advertising positions (e.g. through HPSS-wide job trawls) and disseminating written information on positions (i.e. job descriptions, personnel specifications, terms and conditions) to all existing and new doctors.

(6) The Agency will seek to produce a Code of Practice for the appointment of medical and dental practitioners to become members of Specialty Training Committees.

(7) The Agency will encourage Committees to explore the viability of introducing the use of videoconferencing facilities and rotating the venue of meetings. Agency will provide Committees with advice and guidance on range of locations and venues available, esp. outside of Belfast. Agency will encourage Committees varying meeting times and considering availability of childcare wherever possible.

(8) Equality data on seven of the nine groups will be collected at the application stage in order to allow for ongoing monitoring in compliance with provisions under the Data Protection Act.

(9) Summary monitoring data will be published on an annual basis to provide greater transparency as to applicants and appointees.

(10) The Agency will include a statement in future advertisements that NIMDTA is an equal opportunities employer (spelling out all nine groups) and that applications from the under-represented groups will be particularly welcome.

(11) The Agency will seek to further develop its engagement with organisations representing the interests of Section 75 groups, in particular with regards to exploring potential barriers and ways of addressing them.

(12) The Agency will introduce both equality awareness training and induction training for those working on its behalf; it will also distribute information materials on equality to staff.

(13) The Agency will continue to lobby the DHSSPS for supporting the collection of quantitative monitoring data on all GPs, GDPs and hospital consultants.

4.3 Monitoring

Within the course of the third quarter of 2004/2005, a delivery plan will be drawn up to implement specific action points emanating from the assessment. The delivery 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 be explored, pending also the publication of further advice by the Equality Commission.

The Agency commits itself to revising the policy if monitoring shows adverse impacts.

APPENDICES

Appendix 1: The Steps of an EQIA

- **What is it we are actually looking at? (‘Aims of Policy’)**
  The first part of an EQIA involves thoroughly understanding the policy to be assessed; what context it is set in; who is responsible for what; what links there are with other organisations or individuals in implementing the policy etc..

- **How can we tell what is happening on the ground? (‘Consideration of Data’)**
  This involves reviewing what data is available in-house or elsewhere and identifying what data needs to be newly collected. ‘Data’ means both statistics and the views, experiences and suggestions of those affected by the policy. ‘Collecting new data’ means going out and doing a survey and also talking to people who are affected by a policy or those who are involved in implementing the policy (e.g. delivering a service).

- **So are there any problems for any of the groups? (‘Assessment of Impacts’)**
  All relevant data that has been identified (whether collected from available sources or newly gathered) is brought together and analysed. Conclusions are drawn as to the impact of the policy on the nine groups.

- **What can be done to make things fairer? (‘Consideration of Measures’)**
  Now the findings are related back to action: what can be done to address any inequalities/ unfairness that the analysis of the data has revealed.

- **Are we getting the right picture and are we thinking of doing the right thing? (‘Formal Consultation’)**
  The findings and the proposed actions are brought back to the public at this stage, usually on the basis of a draft report. Now it’s time to find out what people think about the analysis and proposals.

- **With what people have told us – what are we going to do? (‘Decision by Public Authority’)**
  After the wider public has had a chance to comment on the analysis and proposals it’s time for the organisation

to take final decisions and commit themselves to action points.

- **This is what we have found out and this is what we will do ('Publication of Results of EQIA')**
  These decisions and commitments are published in a final report alongside the findings from the analysis of collected data and the comments raised by the wider public during formal consultation.

- **Keeping a close eye on what is happening ('Monitoring of Adverse Impacts')**
  An EQIA is not a one off. It's important to keep a close eye on ('to monitor') what difference the changes to the policy actually make.

Appendix 2: The Quantitative Questionnaire

Gender:

Male ☐

Female ☐

Trans ☐

Age: *Please indicate your year of birth:* ____________________

Marital Status:

Single ☐

Married ☐

Co-habiting ☐

Separated ☐

Divorced ☐

Widowed ☐

Other ☐

Dependants

Do you look after or give support on a regular basis to either a family member, friend or neighbour belonging to one of the following groups:

- a dependant child or young person Yes ☐ No ☐
- a person with a long-term physical or mental health problem Yes ☐ No ☐
- a dependant elderly person? Yes ☐ No ☐

Religious affiliation:

Regardless of whether we practice religion, most people in Northern Ireland are seen as either Catholic or Protestant. We are therefore asking you to indicate your community background by ticking the appropriate box below:

Roman Catholic Community ☐

Protestant Community ☐

Neither ☐ (please specify)___________________

Ethnicity

Please tick the appropriate box to indicate your ethnic origin and specify your nationality:

White ☐

Irish Traveller ☐

Chinese ☐

Indian ☐

Pakistani ☐

Bangladeshi ☐

Black-African ☐

Black-Caribbean ☐

Mixed ethnic group ☐

Any other ethnic group (please describe)___________________________

Nationality (please describe)_____________________________________

Disability

In accordance with the Disability Discrimination Act 1995, a disability is defined as "a physical or mental impairment that has substantial and long term adverse effect on your ability to carry out normal day to day activities". Do you consider yourself to have a disability?

Yes ☐ No ☐

If **Yes** please specify the nature of your disability and, if applicable, provide details of your specific requirements so that we can make any necessary reasonable adjustments or adaptations that will improve your access to our services, make reasonable adjustments to working arrangements and/or ensure that you enjoy equal participation in working with us.

____
____
____
____

Any other comments

Would you like to comment on any of the above questions?

Appendix 3: The Qualitative Questionnaire

Dear Colleague,

Re: Equality Impact Assessment on Appointment of Staff to Act on Behalf of the Agency (Specialty Advisers, Training Programme Directors, Tutors and Course Organisers)

The Northern Ireland Medical and Dental Training Agency (NIMDTA) is a public body under the terms of Section 75 and Schedule 9 of the Northern Ireland Act 1998. We are required to promote equality of opportunity and good relations in carrying out our functions.

One of the key undertakings in our Equality Scheme was that we should carry out 'equality impact assessments'. These assessments look at the impact of our work on different groups of people and are meant to ensure that our policies promote equality of opportunity between:

a) persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation
b) men and women generally
c) persons with a disability and persons without
d) persons with dependants and persons without.

A key policy which has been identified for assessment during 2003/2004 is the appointment of staff to act on behalf of the Agency (Specialty Advisers, Training Programme Directors, Tutors and Course Organisers).

In order to find out more about the perceptions of GPs, GDPs and Consultants as the key stakeholders of this policy, we have designed a brief questionnaire. It asks you to share your views, experiences and suggestions in relation to current procedures and practices.

We would be grateful if you could spend some 10 minutes to consider the following questions and return the attached sheets to us by **6 October 2003**.

We look forward to learning more about your views.

Yours sincerely,

Equality of Opportunity Questionnaire

on

Appointment of Staff to Act on Behalf of the Agency (Specialty Advisers, Training Programme Directors, Tutors and Course Organisers)

In the first place, are you aware of the current arrangements for appointment to Specialty Training Committees and have you ever considered seeking appointment to a committee?

What do you think are currently the main barriers to becoming a member of a committee?

Are there any groups (in terms of age, gender, religion, political affiliation, racial group, marital status, dependent status, disability or sexual orientation) who you think might find it particularly difficult to gain membership of a committee at the moment? If so, why?

Do you perceive any other inequalities to be at work regarding access to committee membership, beyond the groups listed above? If so, how important are they in comparison?

Turning now to Agency positions, are you aware of the current arrangements for appointment to any of these positions (Specialty Advisers, Training Programme Directors, Tutors and Course Organisers) and have you ever considered seeking appointment to any of them?

What do you think are currently the main barriers to accessing these positions?

Are there any groups (in terms of age, gender, religion, political affiliation, racial group, marital status, dependent status, disability or sexual orientation) who you think might have particular difficulties accessing these positions at the moment? If so, why?

Do you perceive any other inequalities to be at work regarding access to these <u>positions</u>, beyond the groups listed above? If so, how important are they in comparison?

What do you think the Agency could do to promote greater fairness in relation to access to these positions and membership of committees?

Would you personally consider applying for any of these positions if they were publicly advertised?

Advisor	**Yes**	❑	**No**	❑
Programme Director	**Yes**	❑	**No**	❑
Clinical Tutor	**Yes**	❑	**No**	❑
Course Organiser	**Yes**	❑	**No**	❑

Finally, are you …

…a GP ❑ **a GDP** ❑ **a Consultant** ❑

Please indicate your specialty:

A&E	Anaesthetics
Laboratory Medicine	Medical Specialties
Clinical Oncology	O&G
Occupational Medicine	Ophthalmology
Orthopaedic Surgery	Otolaryngology
Paediatrics	Psychiatry
Public Health Medicine	Radiology
Surgical Specialties	Dentistry

Appendix 4: Tables Summarising Collected Section 75 Data

Table 1: Gender

	female	**male**
Census population (2001)	49.6	50.4
Committees total	28.2	71.8
positions total	24.2	75.8
Hospital Specialties - positions	17.9	82.1
GPs – positions	38.5	61.5
GDPs – positions	22.2	77.8
Hospital Specialties – Committees	25.8	74.2
GPs – Committees	33.3	66.7
GDPs – Committees	34.6	65.4
Consultant population (2001)	22	78
GP population (2001)	33	67
GDP population (2001)	39	61
Consultant+GP+GDP total (2001)	31	69

Table 2: Age

age band	C+GP+GDP in %	consultants in %	GPs in %	GDPs in %	positions in %	Hospital positions in %	GP positions in %	GDP positions in %	STC in %	Hospital committees	GP committees	GDP committees	Census in % of 25-64
25-29	4.6	0	0.5	17.5	0	0	0	0	1.1	0	3.1	6.7	13.46
30-34	9.8	3.0	8.7	21.5	1.2	0	4	0	0.6	0	3.1	0	14.96
35-39	20.2	21.0	17.7	23.4	11.9	9.8	16	12.5	12.2	10.5	12.5	26.7	15.21
40-44	19.7	22.0	20.7	14.3	25	25.5	32	0	20.6	21.1	28.1	0	13.77
45-49	18.7	21.0	21.7	10	27.4	29.4	20	37.5	27.8	30.1	18.8	26.7	12.02
50-54	13.5	16.0	16.8	4.9	8.3	7.8	8	12.5	15	15	12.5	20	11.55
55-59	9.7	12.0	10.2	6.4	22.6	23.5	16	37.5	17.8	18.8	12.5	20	10.41
60-64	3.7	5.0	3.8	1.9	3.6	3.9	4	0	4.4	4.5	6.3	0	8.63

Table 3: Religion

	Catholic	Protestant	Other religion, no religion or religion not stated
Census population (2001)	38.7 [45.26]	46.8 [54.74]	14.5
Committees total	31.5 [35.88]	56.3 [64.12]	12.2
positions total	31.5 [33.76]	61.8 [66.24]	6.7
Hospital Specialties – positions	33.3 [35.96]	59.3 [64.04]	7.4
GPs – positions	34.6 [36]	61.5 [64]	3.8
GDPs – positions	11.1 [12.49]	77.8 [87.51]	11.1
Hospital Specialties – Committees	31.1 [36.5]	54.1 [63.5]	14.9
GPs – Committees	30.8 [32.46]	64.1 [67.54]	5.1
GDPs – Committees	34.6 [37.49]	57.7 [62.51]	7.7

N.B.: The figures in brackets correspond to percentages of the total of those who indicated that their religious background is either Catholic or Protestant.

Table 4: Ethnicity

	white	black and minority ethnic
Census population (2001)	99.19	0.81
Committees total	95.77	4.23
positions total	98.9	1.1
Hospital Specialties - positions	98.2	1.8
GPs – positions	100	0
GDPs – positions	100	0
Hospital Specialties – Committees	94.6	5.4
GPs – Committees	97.4	2.6
GDPs – Committees	100	0

Table 5: Marital Status

	single	married	separated	divorced	widowed
Census population (2001)	22.8	63.7	5.3	5.7	2.5
Committee total	7.9	88.4	1.9	1.4	0.5
positions total	5.5	89	1.1	3.3	1.1
Hospital Specialties - positions	8.9	85.7	1.8	1.8	1.8
GPs – positions	0	100	0	0	0
GDPs – positions	0	77.8	0	22.2	0
Hospital Specialties – Committees	7.9	88.1	2.6	0.7	0.7
GPs – Committees	2.6	97.4	0	0	0
GDPs – Committees	15.4	76.9	0	7.7	0

Table 6: Disability

	with limiting long-term illness
Census population (2001)	20.64
Committee total	2.8
positions total	2.2
Hospital Specialties – positions	1.8
GPs – positions	3.8
GDPs – positions	0
Hospital Specialties – Committees	2.0
GPs – Committees	7.7
GDPs – Committees	0

Table 7: Carers of disabled and/or elderly dependants

	carers
Census population (2001)	17.1
Committees total	19.6
positions total	16.9
Hospital Specialties - positions	16.4
GPs – positions	15.4
GDPs – positions	25.0
Hospital Specialties – Committees	17.7
GPs – Committees	18.9
GDPs – Committees	35

Table 8: Carers of children

	w/ dependent children
Census population (2001)	49.3
Committees total	68.7
positions total	68.1
Hospital Specialties - positions	67.9
GPs – positions	73.1
GDPs – positions	55.6
Hospital Specialties – Committees	68.2
GPs – Committees	74.4
GDPs – Committees	62.5

NB: The 2001 Census data is based on all adults in households rather than the entire population.

Appendix 5: 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 policy 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 6: List of Consultees

Organisation
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
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
Filor Housing Association
First Key
Fold Housing Association
Forum For Action On Substance Abuse
Foyle Down's Syndrome Trust
Foyle Friend
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
Newtownabbey 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 Women’s 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 Council
Probation Board for NI
Progressive House
Prospects for People with Learning Disabilities
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 Agency
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 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 Equality and Human Rights Forum
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 7: Comments Received During Consultation

Specific Comments	**Comments Received**	**Response by NIMDTA**
The Rainbow Project	• No specific questions regarding political opinion or sexual orientation were included in the survey, questionnaire or interviews. The finding that "no evidence emerged regarding adverse impacts" on these categories is misleading and inadequate. • The report excludes two of the Section 75 categories, and provides no compelling reason for doing so.	• While no specific questions on political opinion and sexual orientation were asked in the quantitative survey, they were explicitly included in the qualitative questionnaire. Participants were asked to comment on perceived inequalities with regard to all nine groups (see Appendix 3 of the draft and the final report for a copy of the questionnaire). With the exception of one respondent no concerns were expressed in relation to these two categories – hence the conclusion that no evidence emerged. • In the section on 'data collection' of the draft and the final report, the Agency provides the rationale for not surveying the category of political affiliation in its quantitative

		questionnaire: the strong reluctance of staff to reveal their political affiliation in a recent anonymous survey on good relations within the Agency. This renders any quantitative measuring highly inaccurate. see new paragraph within section on 'data collection and consultation' regarding the rationale for excluding sexual orientation from the quantitative questionnaire
	• There has been no action plan or points made to change this position by NIMDTA.	• Agency has committed itself to exploring further options for qualitative monitoring in the course of the first quarter of the new financial year (see section on 'Monitoring'). The publication of further advice by the Equality Commission will be crucial to inform this.
	• Other organisations (such as the Association of Northern Ireland	• Agency will be keen to find out more about these organisations' experiences in quantitative

	Colleges and the Construction Industry Training Board, etc.) already monitor in relation to these categories, as well including them in the collection of data for their EQIA.	monitoring. Agency would argue that the specifics of the policy under assessment (esp. the nature of its target group) must be taken on board to decide on the most appropriate methods for collecting data and monitoring – e.g. posing a question on sexual orientation in a quantitative questionnaire of medical and dental practitioners might not automatically be as effective as posing this question to a group of students. The Equality Commission (2001a, p.13) states that "consideration should be given as to how appropriate particular methods may be for each of the nine equality categories". The Commission reiterates the need for public authorities to decide on the most appropriate method of monitoring on sexual orientation in its most recent publication on sexual orientation (Equality Commission 2004).

	• NIMDTA should begin collecting information on sexual orientation and political opinion as soon as possible, both with regards to EQIAs and more general monitoring. • NIMDTA should mention all nine categories by name when calling itself an equal opportunities employer in advertisements. Groups that have been historically discriminated against may not see themselves as included in the phrase "equal opportunity employer" unless the group is mentioned by name. • It is unclear from the proposed action points whether people of differing political beliefs or sexual orientation will be included in the targeting of under-represented groups. Since no data was gathered in regards to these groups, it seems obvious the Agency will not be	• NIMDTA awaits further definite guidance by the Equality Commission regarding monitoring (esp. quantitative monitoring) for the two groups, as referred to in the report's section on 'monitoring'. • The Agency commits itself to spelling out all nine groups in its statement on being an equal opportunities employer (see amended text on action point 10) • Agency notes the comment.

	targeting these groups as under-represented. • NIMDTA should be aware that there are sensitivities in gathering such information and they should contact the relevant groups for advice. NIMDTA can acknowledge both the sensitivity and the importance of these categories by working in collaboration with the relevant agencies to rectify the lack of information.	• The Agency will seek to further develop its engagement with organisations representing the interests of LGBT people (see new action point 11).
British Medical Association (BMA)	• commends Agency for the openness and transparency with which it has conducted this assessment and would encourage the Agency to continue in this attitude • in general agreement with all of the proposed action points • underlines importance of introducing open, transparent and consistent appointment process across all positions and specialties – recognises	• Agency notes the comment • Agency notes the comment • Agency commits itself to publish information regarding any exceptional circumstances (see amended text on action point 1)

	exceptional circumstances can arise whether this may not be rigorously applied; Agency should apprise BMA when and why these exceptional circumstances happen • strong support for a Code of Practice for appointment of practitioners to become members of Specialty Training Committees • any future publication should be proofed by the Plain English Campaign to ensure accessibility for as many as possible	• Agency notes the comment • Agency commits itself to applying new guidance on 'Cracking the Information barrier in Health, Social Services and Public Safety – The 5 C's of Information Provision' in all their publications (see amended text on action point 1)
Doreen Wilson Chief Dental Officer DHSSPS	• policy staff in DHSSPS Dental Branch concur with finding re: lack of transparency and openness and see this as the main cause of current inequalities; if this issue is appropriately addressed then the other issues relating to under-representation of females, Catholics and younger	• Agency agrees with the comment

	members of the profession will potentially be resolved • proposal to provide ongoing monitoring of data on seven of the nine groups is endorsed; should also extend to current postholders to provide baseline information • proposal to commence advertising positions which become vacant on a fixed term basis is endorsed; would contribute to delivering an effective postgraduate organisation with dynamic thinking and opportunity for career development	 • Agency agrees with the comment; the data collected during the EQIA should provide a first baseline regarding current postholders • Agency agrees with the comment
Dental Surgeon	*interview panels and the interview process:* • interview panels have been made up of too few for too long; diversity of panels has not been encouraged	 • The make up of the panel would usually include: the Chair of Committee on Vocational Training (CVT NI) a VDP trainer, a past trainee, the Dental Adviser and a person from the CSA's HR directorate. In line with the

		legislation, the Agency would always ensure a gender and religious balance.
	• steps should be taken to have a recruitment drive each year; names should be submitted each year from as diverse a base as possible i.e. include all nine groups	• This does not seem practical as only very few recruitment exercises currently take place (there have been only two over the last five years in the dental section). However, the Agency commits itself to explicitly encouraging individuals from some of the under-represented groups to become involved (see new action point 4).
	• people should be provided with the appropriate training to sit on panel; training must be appropriately funded and training sites must be based in several locations; training should include 'interview training skills' courses to be included within each 3 year cycle	• All members of recruitment panels receive selection and recruitment training (both panels for positions to act on behalf of the Agency and for the VDP scheme). It is also compulsory for all VDP trainers.
	• any work relating to interviews must be completely funded and at a time to suit most of the panel; location should be	• panel members are entitled to claim for loss of earnings allowance as well as mileage allowance

	decided by panel to accommodate everyone esp. those from practices outside Belfast • interview panels must be disclosed to DPC to enable discussion of fair representation *advertisements for posts* • to be circulated to all dentists rather than solely relying on advertisements through newspapers and BDJ • circulation along with their monthly pay-cheque would be most effective • advertisements also to be alerted to in advance of LDC meetings • Boards also to be involved in increasing awareness of job availability	• Agency notes the comment. *Agency considers these suggestions very useful and will incorporate them in the communication strategy to be drafted as action point 5*

	job descriptions	
	• need for detailed job descriptions	• Agency agrees with the comment – see action point 3
	accountability	
	• staff must become more accountable to Dental Profession	• Agency notes the comment
	• do the number of service providers justify the service or is too much money spent on dental wages?	• Agency notes the comment and will share it with DHSSPS who is responsible for setting the Agency's budget including separate budgets for dental wages and education.
	• Agency should consider option to have someone in each Board employed to organise local meetings and who liaise to organise larger central meetings – need for further drive to disseminate courses into the four Boards	• regular meetings take place between the Agency and the Boards regarding education matters
	location	
	• location of Agency offices poses barrier	• naturally, a wide range of factors

	to those with caring responsibilities – Agency should consider relocating to a more central location within Northern Ireland	need to be taken into account regarding the best possible location; Agency has just secured new premises on the outskirts of Belfast with the intended move to take place during 2004/2005
	Vocational Dental Practice (VDP) Scheme	
	• VDP scheme generally discriminates against trainers who do not practice within greater Belfast area – further measures needed to address this issue	• The Agency holds three information evenings for potential trainers, two of which always take place in the West. The interviews are held outside Belfast specifically to encourage and facilitate rural applicants. Statistics reveal that 11 of the current training practices are located in the EHSSB, 5 each in the WHSSB and NHSSB and 2 in the SHSSB.
	• VDP trainees recruited almost exclusively from QUB graduates, creating on 'old school network' from the start of working life – need to organise open days to attract those	• Agency notes these comments and will take them on board as it undertakes its EQIA on "The Recruitment of Vocational Dental Practitioners" scheduled for 2004/2005

	from other Dental Schools to apply; a share of the total allocation of VDP scheme should be retained for non-QUB graduates	
Anne McGlade Eastern Health and Social Services Board	• issues raised by respondents and being addressed by the recommendation should ensure better outcomes • ongoing review will be important	Agency notes the comments
British Dental Association (BDA)	• staff of the Agency should be equality conscious and able to indicate that diversity and equality issues have been identified and supported all staff, committee members and committee chairs and those wishing to become involved need to be trained and updated on equality • equality issues need to be monitored and revisited on an ongoing basis • transparent and clearly understood	• the Agency's administration staff have all received equality training; Agency will introduce both equality awareness training and induction training for those working on its behalf; it will also distribute information materials on equality to staff (see new action point 12) • Agency agrees with comments and has committed itself to monitoring (see section on 'monitoring') • Agency notes the comment (see also

	code of conduct is needed that all members of staff and committees are expected to observe – every person needs to take responsibility for promoting equality of opportunity for all nine groups	action point 6)
	• possibility of providing equality and diversity training to members of the dental profession as Continuing Professional Development (CPD) must be explored	• Equality awareness training is already provided for dentists as part of CPD during 2004/2005
	• Agency should raise awareness of its role and remit through literature and recruitment campaigns by producing literature, advertising committee vacancies through publications disseminated to all dentists, marketing the Agency in more family friendly terms, and highlighting personal benefits to involvement and benefits to Agency	• Agency notes suggestions and will take them on board when developing its communication strategy. Information on the role of the Agency is currently available on the website and distributed to all SpRs. The dental department will shortly begin publishing information on the membership of all its Committees.
	• remuneration – reconsider underlying assumption that committee members	• Committee members are currently paid BDA guild rate (£220 per

	will be financially secure enough to pay expenses out of pocket and wait to be reimbursed; poses barriers for single-handed GDPs, part-timers, people with dependants – introduce new methods	session) as well as mileage expenses. Agency commits itself to reviewing its administration procedures to explore the scope for speeding up the payment process.
	• Agency should provide Committees with advice and guidance on range of locations and venues available, esp. outside of Belfast	• see amended text on action point 7
	• Agency should encourage varying meeting times	• see amended text on action point 7
	• availability of childcare should be considered wherever possible	• see amended text on action point 7
	• cramped physical environment in current Agency premises – Agency should create a more positive environment	• Agency will move into new premises during 2004/2005
	• wider use of technology in reducing issues associated with geography would be beneficial (e.g. audio and video conferencing)	• as an outcome of its EQIA on GDP Continuing Dental Education the Agency is currently investigating the feasibility of using video conferencing

	• advertising of posts – should be undertaken in a variety of publications (Belfast Telegraph, BDJ and throughout particular specialties) • sensitivities surrounding the monitoring of sexual orientation and political affiliation are understandable; Agency should make clear what alternative and less intrusive approaches they intend to take to ensure that such discrimination does not take place	technology • Agency notes comment, to be taken on board in its development of a communication strategy • the Agency will explore further options beyond employing qualitative questionnaires of the kind used in the EQIA with organisations representing interests of people from these groups and with the help of pending guidance by the Equality Commission
Dr Gerard Daly Consultant Physician	• pleased with the assessment as a respondent to the questionnaire • Agency can grow further in strength from the policies proposed in the draft report	Agency notes the comment
Denis Jordan Evaluation and Equality Unit	• clear definition of the policy would be helpful (esp. its aims and objectives) – perhaps it is more clearly defined in the	• Agency has amended the text of the summary report accordingly (see section on ‘The Policy’) – the full

DHSSPS	full report • report in some places refers to 'the policy', in others to 'the policies' – creates confusion • was any attempt made to find out why there was a low response rate from GPs and GDPs to the qualitative questionnaire? • while there are many references to absence of data, I think what is most important is that the Agency accepts that there is a problem and has committed to undertaking a series of actions to rectify the situation; a Code of Practice is a particularly good idea	report provides further information on the policy • Agency has amended the text accordingly • the question was posed to the BDA at a consultation meeting; two possible explanations were advanced by the BDA: (1) the length of the questionnaire and (2) the fact that it had to be returned to the Agency rather than an external facilitator • Agency notes the comment
Disability Action (DA)	• in relation to widening the application of the Agency's existing appointment procedures and practices DA requests	• These details will be determined in the delivery plan to be drafted by the end of the first quarter of the new

	specific actions, targets, expected outcomes and a timeframe to enable informed comment to be made (see bullet 1 on p.31 of the draft report)	financial year.
	• DA welcomes the collection of data at the application stage, however requests a commitment to the monitoring of successful candidates and the publication of this data (see bullet 2 on p.31 of the draft report)	• Agency agrees with the comment and would like to refer to its commitment to publish summary monitoring data on applicants and appointees (see bullet 3 of draft report and action point 9 of final report)
	• Agency must include outreach work to encourage applications from under represented groups and to remove perceived inequality and perceived barriers outlined (see pp. 23-25 of the draft report)	• Agency commits itself to engaging with voluntary sector organisations to explore potential barriers and ways of addressing them further (see new action point 11).
	• although Agency has identified adverse impact across seven of the nine categories DA remains unclear as to how the proposed action points will lead to mitigation; DA believes that this renders this EQIA open to question	• Agency notes comment. It would hold that in aiming to provide transparency and openness of the appointment process action points 1 to 6 will form an important basis for promoting greater equality of

	renders this EQIA open to question	opportunity for members of <u>all nine groups.</u> Action points 7 and 10 to 13 (including new action points 11 to 13) aim at providing the basis for addressing the needs of particular groups
Special EU Programmes Body	• disappointed that the EQIA let the issue of non data allow it to brush over a lot of key groups, especially black and ethnic groups • the issue of racism was not addressed because of the 'absence of data'; limited ethnic diversity amongst Agency positions does not need data to prove an adverse impact • action proposed by the organisation is not appropriate for addressing the issues • Agency should go beyond the statistics; if you have no black or ethnic members on the Agency then there will be no data, that does not mean that racism	Agency notes the comments. It would like to point out, however, that, in drawing conclusions from the quantitative data collected, it is important to remind oneself of the scope of the policy. Those appointed by the Agency to act on its behalf are recruited from the pool of all medical and dental practitioners in Northern Ireland. At this stage we simply do not know the ethnic composition of the pool that the Agency can draw its staff from. In other words, it is possible that an observed lack of ethnic diversity amongst Agency staff may well reflect a lack of diversity in the pool of potential postholders i.e. barriers being at work for people from black and minority ethnic groups to become medical and dental

	has no impact • EQIA is tick box driven and conservative in its methodology and conclusions	practitioners in the first place. Hence the statement urging caution in the interpretation of the quantitative data as automatically indicating adverse impacts of this policy. (see p.22/23 for a more lengthy discussion of the issue around quantitative data on ethnicity) Nevertheless, the Agency commits itself to further work regarding race awareness (see new action points 12 and 13).
Lynn Lappin Craigavon Area Hospital Group	• report addresses all equality issues in relation to the policies • actions proposed by Agency appropriate for addressing the issues	Agency notes the comments

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