



Health and Social Care Bill 2011

Equality Impact Assessments

Equality Impact Assessments for the Health and Social Care Bill

This document is the Equality Impact Assessments (EIAs) for the Health and Social Care Bill, 2011. It provides the six EIAs that accompany the Bill, which cover:

Annex A	Commissioning for patients
Annex B	Regulating providers
Annex C	Local democratic legitimacy
Annex D	HealthWatch
Annex E	Public bodies
Annex F	Public health

There is also an additional Annex (G), which provides evidence to support the EIAs.

This should be read alongside the “Coordinating document”. They also link across to the Impact Assessments, which correspond to the Annexes listed above and have been published as a separate document.

Equality Impact Assessment:

Annex A: Liberating the NHS – Commissioning for patients

Introduction

- A1. In order to shift decision-making as close as possible to individual patients, the Department will devolve power and responsibility for commissioning the great majority of health services to local groups of general practices called GP consortia. This change will build on the role that primary care professionals already play in coordinating patient care. GP consortia will bring together responsibility for management of care with the management of resources.
- A2. To support GP consortia in their commissioning decisions, a statutory NHS Commissioning Board will be established. This national body will provide overall leadership for quality improvement, and ensure the development of GP consortia and allocation of their resources, holding them to account for outcomes and financial performance. It will also promote patient and public involvement and choice.
- A3. It is proposed that the Board will be responsible for commissioning a number of services, for example, primary medical care (GP practices); dentistry, community pharmacy and primary ophthalmic services; prison health services, services for the armed forces and some other national and regional specialised services. Although consortia will not be directly responsible for commissioning primary medical services that GPs themselves provide under primary medical services contracts, they will become increasingly influential in driving up the quality of general practice.
- A4. Currently, most health services are commissioned by local primary care trusts (separately, collaboratively or partnership with local authorities) and performance managed by strategic health authorities. These bodies will be abolished by 2013. Through the introduction of GP consortia, supported by a national commissioning board, the Government aims to:
- Empower clinicians, giving them greater autonomy to shape services around the needs of patients
 - Ensure that commissioning decisions are informed by robust clinical insight
 - Enable greater, more direct accountability to patients and the public, bringing together responsibility and accountability for clinical decisions and the financial consequences of those decisions
 - Enable more productive dialogue and partnerships with hospital specialists and other healthcare professionals
 - Increase system efficiency, removing any unnecessary intermediate steps in commissioning healthcare
 - Achieve better health outcomes

Relevance to Equality and Diversity

- A5. The purpose of this equality impact assessment (EIA) is to inform development of this policy so that, as far as possible, it:

- (i) Eliminates discrimination and does not generate or exacerbate inequalities in access to healthcare or health outcomes for patients and the public or employment and progression opportunities for actual/potential employees;
- (ii) Supports local efforts to reduce inequalities, promote equality and foster good relations between people from protected groups and those who are not.

A6. In carrying out this assessment, we have considered the following dimensions:

- Age
- Disability
- Gender reassignment
- Pregnancy and maternity
- Race or ethnicity
- Religion or belief
- Sex
- Sexual orientation
- Socio-economic status

A7. We have chosen to include all the relevant protected characteristics covered by the Equality Act in accordance with good practice guidance from the Equalities and Human Rights Commission (EHRC). Not all the provisions of the Equality Act are yet in force; some, such as the prohibition on age discrimination in services and public functions are still under consideration, and the public sector equality duty is due to commence in April 2011. Our consideration of these characteristics takes into account that we expect these measures to be in force when these provisions come into effect.

A8. Socio-economic status is not one of the protected characteristics that must be covered in the public sector equality duty and therefore in the EIA, but has been included for completeness of impact on current health inequalities.

A9. In addition, where a change affects employment of staff, the effect on marriage and civil partnerships is considered. Some of the provisions in the Bill give effect to policies which will have an impact on staff currently employed in existing or new bodies. The three organisations concerned (the Department of Health, NHS and DH's arm's length bodies) are developing Human Resources frameworks based on common principles to ensure that staff whose employment is affected by the system reconfiguration are treated fairly and equitably. These principles, which will inform and determine the frameworks' individual content, will be agreed with Trade Unions. The composition of the initial frameworks is subject to consultation with Trade Unions as will be any revisions to the frameworks.

A10. One of the principles, equality, recognises the importance of a diverse workforce and will help to ensure that no employee receives less favourable treatment on the grounds of age, disability, gender re-assignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, gender or sexual orientation, or on the grounds of trade union membership.

- A11. The commissioning of healthcare services can have a direct impact on the health and well-being of communities. However, evidence shows that not all population groups have equal access to services or experience equality in health outcomes. It is therefore important that any national commissioning policy be informed by an assessment of the possible effects on groups and communities that may have experienced discrimination or disadvantage based the characteristics listed in paragraph A6.
- A12. The Secretary of State's functions pertaining to commissioning will be directly conferred upon the NHS Commissioning Board and GP consortia. As public bodies, GP consortia and the NHS Commissioning Board will have a statutory obligation to meet both the general and specific duties of the Equality Act 2010.¹

The Equality Act 2010 and powers of the Secretary of State

- A13. The Equality Act aims to simplify, harmonise and strengthen equality law, replacing nine major pieces of legislation and around 100 other instruments with a single Act. It received Royal Assent on 8 April 2010. The main provisions in the Act came into force in October 2010 and the single public sector equality duty will come into force in April 2011².
- A14. The single public sector equality duty covers race, disability, and gender (existing duties), plus age, sexual orientation, religion or belief, pregnancy and maternity, and gender reassignment. These dimensions are collectively referred to as the protected characteristics. All public bodies, including those changed or set up through these provisions, must have due regard to the need to:
- eliminate unlawful discrimination, harassment, and victimisation;
 - advance equality of opportunity; and
 - foster good relations between those who share a relevant protected characteristic and those who do not.
- A15. This general duty is underpinned by specific duties, to help public bodies meet the general duty. The Government has recently undertaken a public consultation on the specific duties.
- A16. The Equality Act 2010 will ensure that all public bodies within the health service, including the NHS and the public health service, are obliged to comply with principles of equality. This will include those bodies established under the Bill, such as GP consortia, and those whose functions are changed, such as some of the arm's-length bodies (CQC, NICE and Monitor). These duties also apply to private providers in so far as they are providing NHS services, on the basis that the provision of services for the purposes of the health service is a function of a public nature. This can be brought about by measures such as the inclusion of contractual

¹ The general duty is set out in section 149 of the Equality Act 2010. Those subject to the Equality Duty must have due regard to the need to eliminate unlawful discrimination, harassment and victimisation; advance equality of opportunity between different groups; and foster good relations between different groups. Specific duties are legal requirements that help public organisations meet the general duty.

² From April 2012, the ban on age discrimination in provision of goods, facilities, services and public functions will be implemented.

terms relating to equality in contracts with such organisations, where this is considered necessary.

- A17. The Government's current consultation document on the specific duties proposes that statutory organisations set out the equality outcomes they aim to achieve, including specific and measurable objectives outlining how they plan to achieve them.³ It is intended that this approach will be in line with the cross government agenda of transparency and democratic accountability; patients and the public should be able to see progress against their stated objectives and judge whether GP consortia or the NHS Commissioning Board are working toward the right equality outcomes.
- A18. The transition to commissioning by the NHS Commissioning Board and GP consortia will also have a significant impact on existing NHS employees, and a potential impact on future employees, working within the new commissioning landscape. It is critical that in the transition phase, protected groups are not disproportionately represented in the numbers of staff at risk and have equal access to any new employment or development opportunities.

Summary of Evidence

- A19. This EIA relies on evidence and stakeholder feedback to:
- provide supporting evidence where actual or potential impacts on equality and human rights were identified
 - assist with developing proposals for mitigating potential negative impacts
 - demonstrate how proposed reforms can promote equality and human rights, where possible
- A20. Table 1 summarises the evidence on access to health services and health outcomes by protected characteristic. This section outlines the available evidence on the impact of commissioning on equality.
- A21. There is limited intelligence on the impact of commissioning frameworks on health inequalities or the promotion of equality - most available evidence focuses on the commissioning processes or the cost and quality of commissioned services. Indeed, a recurring theme of a 2004 review of primary care-led commissioning was the lack of any robust evidence or systematic assessment of its impact (or the impact of any other commissioning model) on service quality or health outcomes. Its authors stated:
- “Studies need to be developed of the impact of commissioning and planning approaches in relation to specific patient/client groups and services whose needs are a high priority in all four UK countries.”⁴

³ Government Equalities Office (2010) Equality Act 2010: The public sector Equality Duty. Promoting equality through transparency - A consultation. London: Government Equalities Office

⁴ Smith J et al (2004) A review of the effectiveness of primary care-led commissioning and its place in the NHS. London: The Health Foundation

- A22. A Kings Fund report concluded that for commissioners, and in particular primary care commissioners, equity⁵ is 'a troublesome concept with no national frame of reference or measurement'. They cited recent evidence from the Audit Commission (2010) which reinforced this view and showed that inequality is not satisfactorily addressed by commissioners, either alone or in partnership with other agencies. There is little evidence that allocations based on need resulted in any systematic shift of resources to more deprived areas; in some cases, resources directed to 'spearhead' PCTs have been used to meet increased hospital costs.⁶ A study of European health systems also found that although there were some advantages to devolving aspects of commissioning, other areas, such as public health and equity, demanded a national approach.⁷
- A23. Implementation of former GP-led commissioning arrangements may help us to identify any potential impacts of new policy on protected groups. Between 1991 and 1997, GP fundholding allowed self-selecting practices to directly purchase a range of healthcare services for their patients (principally elective care, community services and prescribing). During this time, the policy was further developed to incorporate community fundholding for individual or smaller groups of GP practices who did not wish to commission hospital services and total purchasing, where larger groups of GPs commissioned all hospital and community services.
- A24. In a review of evidence on the effectiveness of primary care-led commissioning, most authors concluded that fundholding increased inequities in access to healthcare, with fundholding practices achieving shorter waiting times for treatment and more information on patient progress than non fundholding practices. This may have been inevitable as practices could opt in or out of fundholding as they wished⁸. Some commentators argued that the capacity of primary care commissioners to promote equality was likely to increase as fund holders became larger population-based collectives⁹, however an evaluation of total purchasing pilots showed that smaller pilots were more likely to report achieving their commissioning outcomes than larger GP collectives.¹⁰
- A25. Practice-based commissioning (PBC) was established in 2004 to enable GPs and other primary care professionals to have greater direct involvement in commissioning primary and community health services for their localities. To obtain feedback from GPs on engagement with and experience of PBC locally, the Department of Health commissioned a series of

⁵ Equity in health implies that no-one should be disadvantaged from reaching their full health potential because of any socially-determined characteristic or position. "It involves the fair distribution of resources needed for health, fair access to the opportunities available, and fairness in the support offered to people when ill." (Whitehead and Dahlgren, 2007). The terms health inequalities and health inequities are often used interchangeably.

⁶ Jones T and Wood J (2010) Improving the quality of commissioning GP services. London: The King's Fund

⁷ Figueras J, Robinson R and Jakubowski E (eds.) (2005) cited in Ham C Health Care Commissioning in the International Context: Lessons from Experience and Evidence. University of Birmingham Health Services Management Centre

⁸ Smith J et al, op. cit.

⁹ *ibid.*

¹⁰ Goodwin N, Mays N, McLeod H, Malbon G and Raferty J (1998) Evaluation of total purchasing pilots in England and Scotland and implications for primary care groups in England: personal interviews and analysis of routine data. *British Medical Journal*. Vol.317, No.7153, pp.256–259

quarterly surveys. The last wave of surveys was conducted between March and May 2010 (Wave 3).¹¹

- A26. No direct questions were asked within the survey on equity of access to or provision of services commissioned through PBC. However, 59% of GP leads reported that PBC had influenced the clinical practice of GP practices within their group, a 5% increase on Wave 1 results. Also, 85% of leads felt able to exert influence with clinicians in their PBC group or practice and over half (53%) felt able to exert influence over care pathways.
- A27. When reviewing the implementation of practice-based commissioning to glean some of the early lessons learned, the Audit Commission stated that where some commissioners were better than others, there was a risk that PBC could widen inequalities in access to and provision of services and fragment service delivery. They also expressed concern about possible negative impacts on quality and financial outcomes of services when GPs adopt both a commissioner and provider role.¹²
- A28. It is envisaged that the establishment of GP consortia will improve access and choice, however a review of primary care-led commissioning found that although patients broadly approved of the service changes made by GPs, the promotion of choice did not feature highly in their commissioning approaches. GPs may have referred to different hospitals or specialists or particular services, but rarely offered patients a choice from a range of hospitals or specialists. The authors suggested that this pointed to the need for more robust mechanisms for promoting choice.¹³
- A29. An analysis of access to health services in England also highlighted the importance of individuals, particularly those from disadvantaged groups, to be adequately supported to exercise choice, in order to avoid confusion and possible inappropriate use of acute services:¹⁴
- “Thus services that require a lot of ‘work’ on the part of the patient to access them are less ‘permeable’ than others and this might explain the higher use of Accident and Emergency services amongst disadvantaged groups compared with other groups, as this is a permeable service that is relatively straightforward to access.”
- A30. In a summary of the learning from US and UK GP budget holding, the author stated that “the quality of care delivered by budget holders needs to be measured to ensure that financial incentives do not lead to under diagnosis and under treatment of patients”. In addition to measures of access to services and health outcomes, it was suggested that the use of patient experience measures should also be included in any assessment of quality.¹⁵

¹¹ Department of Health (2010) Practice-based Commissioning Group and Independent Leads Survey: Wave 3 Results. London: Department of Health

¹² Audit Commission (2006) Early lessons in implementing practice based commissioning. London: Audit Commission

¹³ Smith J et al, op. cit.

¹⁴ Goddard MK (2008) Quality in and Equality of Access to Healthcare Services in England. University of York Centre for Health Economics

¹⁵ Ham C (2010) GP Budget Holding: Lessons from Across the Pond and from the NHS. University of Birmingham Health Services Management Centre

- A31. Commissioning organisations require a formidable combination of skills in order to effectively commission healthcare services. This may partially explain why there continues to be considerable variation in the performance of primary care trusts across the country. The World Class Commissioning assurance process sought to address this by identifying a set of 11 commissioning competency areas and assessing the performance of primary care trusts against them.¹⁶
- A32. A retrospective equality impact assessment of the World Class Commissioning assurance framework published in late 2008 highlighted three key areas for action, which are also relevant to future GP commissioning¹⁷:
- Embedding equality and diversity explicitly into commissioning policy and processes. Not only are implicit messages likely to be overlooked or overshadowed, commissioners who wish to be proactive in this area are left without the necessary policy levers required to initiate change.
 - Collecting and using good quality disaggregated data and community intelligence to inform commissioning practice. The health needs of specific equality groups or disadvantaged communities cannot be accurately identified without access to data that is appropriately segmented or meaningful local dialogue.
 - Securing sufficient specialist equality and diversity capacity to support commissioning effectively at a local level.
- A33. Although the process ran for only two years, we can glean some intelligence on areas of commissioning strength and weakness. PCTs showed greatest competence in the areas covering leadership, partnership working, patient and public engagement and assessing/understanding health needs. The greatest *improvements* were found in assessing health needs. The patient and public engagement competency (which included engagement with seldom heard and protected groups) also showed significant improvement, with most PCTs, on average, operating beyond level 2¹⁸ competency.¹⁹
- A34. PCTs continued to experience challenges in prioritising spend; this competency area showed the least improvement across the two years that the framework was in place. Ensuring efficiency and effectiveness of spend was also the area that showed poorest performance, however this competency was a new addition to the framework in 2009/10. Performance on governance remained broadly the same across the two years, with the exception of PCT board performance, which improved significantly.
- A35. Despite this focus on improving commissioning expertise, an analysis of the impact of prioritisation on quality, expenditure and outcomes found that commissioners tended to focus on areas of greatest healthcare spend and not necessarily on areas where the regulator has

¹⁶ Department of Health (2009) World Class Commissioning Assurance Handbook Year 2. London: Department of Health

¹⁷ Carr D and Whittington C (2008) Equality Impact Assessment: World Class Commissioning Assurance Framework and World class commissioning of primary medical care guidance. London: Department of Health

¹⁸ World class commissioning competency levels range from 1 (not sufficiently competent) to 4 (world class)

¹⁹ *ibid.*

identified them as failing. Also, where the commissioner had articulated priority outcome indicators, these were not fully reflected in the priorities of their providers.²⁰

- A36. Generally, PCTs' performance in promoting equality and diversity in planning, delivering and monitoring services has been mixed. According to the Healthcare Commission's 2008 audit of equalities publications, only 75% of PCTs had produced race equality schemes, a statutory duty under the Race Relations (Amendment) Act 2000. However, 88.2% of PCTs had met standard C7e²¹ of the Annual Health Check during 2008/09, an improvement on the previous year's compliance levels (76.3% in 2007/08).^{22 23}
- A37. Access to high quality data in order to identify areas of inequality is a recurrent theme across the NHS. Although public bodies, including NHS Trusts, are obliged to collect service and workforce data disaggregated by ethnicity, gender and disability, the completeness of this data varies considerably. The 2008/09 Annual Health Check found that among PCTs, 87% had met the standard for quality of ethnicity data, the same percentage as in 2007/08.²⁴
- A38. The mixed picture on equality and diversity, including compliance with legislation, may reflect the differences in capacity at a local level. Often the equality and diversity role is added to the portfolio of an existing employee. Where Trusts have dedicated staff, their level of seniority can vary considerably, from relatively junior employees to director-level appointments.
- A39. In recent years, the Department of Health have developed a number of programmes aimed at improving local policy and practice in promoting equality in health service delivery, for example, Single Equality Scheme Learning Sites and, more recently, the Pacesetters programme. Pacesetters focussed on identifying groups experiencing greatest disadvantage and discrimination and engaging with those groups to remove barriers of access and improve health outcomes. The programme has resulted in producing numerous examples of good practice in promoting equality and diversity into the planning and delivery of health services.²⁵

Summary of Stakeholder Feedback

- A40. A number of engagement events were held for the policy strands within the White Paper, including discussion of the NHS Commissioning Board and GP consortia.

Event	Date
SHA Regional Events x 10	Throughout September 2010
Regional Voices Events x 10	Throughout September 2010
Third Sector Consultation Event	30 September 2010

²⁰ Health Mandate (2010) Commissioning in the new world: an analysis of the impact of prioritisation on quality, expenditure and outcomes in the health service. London: Health Mandate

²¹ Standard C7e required organisations to 'challenge discrimination, promote equality and respect human rights'

²² Healthcare Commission (2009) Tackling the challenge: Promoting race equality in the NHS in England. London: Commission for Healthcare Audit and Inspection

²³ Care Quality Commission (2009) NHS Performance Ratings 2008/09. London: Care Quality Commission

²⁴ *ibid.*

²⁵ <http://www.dh.gov.uk/pacesetters>

A41. Stakeholder feedback from these events, and for *Liberating the NHS: Commissioning for patients*, has been fed into this EIA. Feedback from the commissioning consultation tended to be thematic, rather than specific to any protected group. The most common themes emerging from the written responses and consultation events were as follows:

- **Explicit reference to equality duties:** Most stakeholders welcomed the references in the consultation document to the NHS Commissioning Board and GP consortia's duties to promote equality
- **Equalities leadership role for NHS Commissioning Board:** It was felt that the Board should take a strong leadership role in communicating the requirements of the Equality Act 2010, but there was some concern as to whether the Board was too far removed from GP consortia to have oversight of their equality objectives.
- **Fragmentation of healthcare:** A range of stakeholders, including some GP bodies, felt that the increased diversity of provision at a local level might risk worsening inequalities within and between existing commissioning areas. However, there was support for the outcomes-focussed approach across the White Paper in general and recognition that this could go some way to mitigating this potential impact.
- **Budgets and Payments in respect of performance:** Respondents asked that consideration be given to linking income from performance payments to equality outcomes, rather than just overall outcomes - potentially through the planned NHS Equality Delivery System - to ensure that equality is at the heart of all commissioning decisions. They also stated that a flexible approach to service budgets and structure was required, to allow voluntary and private sector healthcare providers in this field to enter the market.
- **Effective data collection:** Stakeholders were clear that collection of disaggregated service and workforce data is critical to effective commissioning and service planning. They also advised that community intelligence from local voluntary and community sector groups should be used to augment quantitative data, particularly when identifying the needs of smaller, seldom heard groups where 'hard' data are not readily available.
- **Commissioning expertise of GPs:** Stakeholders expressed concern that many GPs have had minimal experience of commissioning, particularly complex services that are likely to be commissioned across a number of GP consortia, such as mental health services. GPs also need to make the necessary links across professional boundaries to ensure continuity of care and joined up services, and avoid fragmentation.
- **Public health support to GP consortia:** Stakeholders were unsure that GP consortia would have sufficient public health support, in order to assess health needs across the whole population and commission effectively.
- **Information:** Respondents from mental health groups commented that commissioning needed a system for sharing information and best practice with voluntary sector and helpline services, which have experience of mental health issues and meeting patient needs.
- **Training and support to deliver equality:** With the abolition of primary care trusts (PCTs) and strategic health authorities (SHAs), stakeholders felt that existing support for and knowledge of promoting equality through commissioning could be lost to the NHS. They suggested that this is a key training and development need for the new NHS Commissioning Board and GP consortia.

- **Employment terms and conditions:** The NHS Agenda for Change pay structure and Knowledge & Skills Framework and been robustly tested and developed to deliver a fair and equitable pay system. If GP consortia move away from existing remuneration arrangements and develop their own terms and conditions, trade union representatives felt that the NHS could be at increased risk of litigation under Equal Pay legislation.
- **Diversity of Local HealthWatch²⁶ membership:** Some organisations felt that marginalised and seldom-heard groups were unlikely to approach Local HealthWatch to complain about local services, preferring instead to go to known and trusted advocacy groups.
- **Engagement of local communities and groups:** Stakeholders felt that GP consortia needed to engage and empower their communities and particularly seldom heard groups, not just through Local HealthWatch but also directly with communities or through voluntary and advocacy groups.
- **Promoting choice to all communities:** A number of stakeholders welcomed the expansion of patient choice, but were keen to see further efforts to support vulnerable groups in understanding the choice agenda, including its extent, limitations and implications.

Discussion of Potential Impacts

A42. The transition to a new commissioning landscape presents the NHS with a valuable opportunity to go further and faster in achieving an equitable and excellent health service. For example, the potential positive impacts which we have identified are:

- GPs and the NHS Commissioning Board will have a clear duty to exercise their functions in ways that are designed to reduce inequalities of outcome which result from socio-economic disadvantage. As public bodies, both will be covered by the general and specific public duties of the Equality Act 2010.
- The duty on GP consortia to involve patients and the public, including those from protected or seldom heard groups, ensures that the voice of the service user will be at the centre of planning and making decisions on the range and nature of services to be commissioned.
- The NHS Commissioning Board can issue commissioning guidance to GP consortia, which can include guidance on fulfilling their duty to promote equality when carrying out their commissioning functions.
- GP consortia will also have certain responsibilities for the unregistered patients usually resident within their geographical boundaries. This ensures that marginalised groups who are often not registered with a practice, such as gypsies and travellers, have appropriate access to health services.
- The power for GP consortia to enter into partnership arrangements with local authorities will help to ensure that the health and care needs of local people are met in a holistic

²⁶ Local HealthWatch will act as local consumer champions across health and care. Local Involvement Networks (LiNs) will become the local HealthWatch. Like LiNs, their services will continue to be contracted by local authorities and they will promote patient and public involvement and seek views on local health and social care services. An equality impact assessment of national and local HealthWatch proposals is included elsewhere in this document.

way. It also ensures that intelligence held by local authorities on the needs of protected and seldom-heard communities can be used to inform service planning and delivery.

- The NHS Commissioning Board will have responsibility for national and regional specialised commissioning, ensuring a consistent approach. This is particularly important for people with rare long term conditions who rely on potentially life-saving treatment.
- The NHS Commissioning Board will be responsible for developing an assurance process that holds GP consortia to account for the outcomes they achieve, their stewardship of public resources, and their fulfilment of the functions placed upon them, for instance their duty to promote equality when carrying out their commissioning functions.

A43. There are also aspects of other White Paper policies that have a positive impact on protected groups. For example, the Commissioning Outcomes Framework will ensure that outcome measures are reported by equality strand wherever possible,²⁷ and GP consortia and the NHS Commissioning Board will be required to work closely with local and national HealthWatch²⁸.

A44. Although the policy proposals can support commissioners in carrying out their equality duties, the actual services commissioned at a local level will have a greater and more direct impact on the health inequalities experienced by protected groups. From past performance, primary care commissioners have struggled with the concept of promoting equality through health services. However, in recent years, with the creation of new equalities legislation, increasing scrutiny from regulators, patients and the public, and PCTs employing or buying in specialist support, there have been some improvements in local policy and practice, with a few organisations emerging as exemplars.

A45. Table 1 (see end) sets out the Department's view of what it considers are the potential negative impacts of 'Commissioning for patients' and suggests how the policy can mitigate negative effects or strengthen opportunities to promote equality for each protected group. The remainder of this section discusses key themes arising from the evidence and stakeholder feedback, which cut across the equality strands.

Commissioning Function

A46. A number of stakeholders expressed concern about the dual provider / commissioner role that some individual GPs will hold, believing that diagnosis and treatment would be unduly influenced by consortia budgets and financial incentives rather than led by clinical need. This would have a disproportionate impact on certain protected groups who have limited knowledge of the NHS or feel less able to challenge health professionals.

"Some patients may view GP-led commissioning with suspicion, particularly when their GP refers them for treatment from another GP provider. It will be essential to develop and implement a system that maintains patient trust and protects professional values."²⁹

²⁷ 'Transparency in outcomes – a framework for the NHS'

²⁸ 'Liberating the NHS: Local democratic legitimacy in health'

²⁹ BMA consultation response to 'Equity and Excellence: Liberating the NHS'

- A47. This is mitigated by the fact that consortia will be separate legal entities as commissioning organisations and will not be able to provide services in their own right. GPs will also still be subject to their professional duties as doctors and have to comply with their contractual terms as regards the provision of primary medical services. This should limit the extent that they might be influenced by their new responsibilities. In addition, the NHS Commissioning Board will work with prospective consortia to develop various pieces of guidance, which GP consortia can use to ensure their processes mitigate against any real or perceived conflicts of interest, e.g. guidance on developing their constitution. This guidance should be clearly communicated to patients and the public. This is particularly important for people from economically disadvantaged backgrounds, as evidence shows that they are less likely to trust their GP than more affluent socio-economic groups.
- A48. Evidence from GP fundholding showed that there were inequalities in access to services between fundholding and non fundholding practices. Under the new commissioning arrangements, holders of primary medical care contracts will be obliged to join a consortium and the NHS Commissioning Board will have a duty to ensure the areas for which consortium are established provide comprehensive coverage across England. In addition, evidence from practice-based commissioning surveys suggests that, should GP commissioners demonstrate strong leadership in promoting equality, GP consortia would have the ability to successfully exert influence to embed those approaches within their member practices.
- A49. GP consortia will have a duty to prepare an annual commissioning plan, setting out how it will exercise its functions and in particular, how it will do so with a view to securing continuous improvement in the quality of services that it commissions and the duties as regards financial responsibilities. Many stakeholders welcomed the proposed introduction of payments in respect of performance against agreed health outcome measures and their effective management of resources. However, any system of performance payments for improved outcomes would need to recognise particular areas of disadvantage or communities where the burden of ill health is considerably higher, and the impacts on population health that may be due to other local activities rather than the specific efforts of local GP consortia.
- A50. Many stakeholders expressed a lack of confidence in consortia's collective knowledge and expertise to commission complex services where inequalities already exist in access and outcomes. Mental health services were frequently mentioned as a key area of concern in this regard, particularly among third sector organisations. The NHS Commissioning Board has an important role in mitigating this potential impact. Although a clear aim of this policy is to give GP consortia greater autonomy, the Board is obliged to produce guidance on the discharge of their commissioning functions. GP consortia will also be able to buy in commissioning support, and may wish to do so from mental health organisations with a good track record in working with BME communities and other disadvantaged groups to reduce inequalities and improve mental health outcomes. They will also have a duty to seek appropriate professional expertise to enable them to carry out their functions relating to the physical and mental health of their patients and consortium population. The forthcoming Commissioning Outcomes Framework will ensure that as far as possible, outcomes will be chosen that can be measured by different equalities characteristics, so that the impacts of care on different groups can be clearly seen and any emerging inequalities tackled.

- A51. Stakeholders felt that low-volume services outside the scope of specialised commissioning aimed at smaller, more vulnerable population groups (for example, wheelchair services, audiology, sickle cell services) could fall between GP consortia and the Board, with neither tier taking full responsibility for developing commissioning in these areas. Work is being carried out within the Department of Health to ensure that all current commissioning functions are appropriately allocated within the new system. GP consortia's ability to commission collaboratively or select a lead consortium to commission on their behalf will allow commissioners to benefit from economies of scale where this is considered more appropriate and efficient, or improves patient outcomes.
- A52. Currently, PCTs receive support and advice from local equality leads and regional SHA equality managers on how to embed equality into commissioning activities. There is a risk that existing knowledge and skills in equitable commissioning may be lost in the transition to new arrangements. The White Paper contains no specific reference to any equivalent support for GP consortia, although they will be free to buy in specialist support where required. The NHS Commissioning Board can provide leadership in this area by incorporating equality and diversity in the commissioning guidance it publishes. Providing this steer would be in line with European evidence highlighting the importance of a national approach to tackling inequality.
- A53. The transition period should be viewed as an opportunity to develop the equality expertise of the emerging NHS Commissioning Board and GP consortia, linking it explicitly to their competency as healthcare commissioners. This development can build on existing learning and best practice from initiatives such as the Pacesetters, GP Access and NHS Employers' Equality Partners programmes.

Data Collection

- A54. The robust collection and use of disaggregated data to inform commissioning practice and measure impacts remains a live issue. Some important datasets, e.g. mortality rates, are only disaggregated by age and gender and are often only available to PCT or local authority level. Should GP consortia be smaller than existing commissioning areas, this may present a challenge to commissioners wishing to access data relevant to their commissioning locality.
- A55. Specific guidance on the public sector equality duties and standards for equalities data collection will be issued in early 2011, which may mitigate these issues. In addition, the forthcoming Information Strategy³⁰ is an opportunity for the NHS to develop a consistent approach to equality data collection and disaggregation, to ensure that patients and the public are able to accurately compare GP consortia and if necessary, apply local pressure to improve performance.
- A56. Even with improvements in data collection, there will be vulnerable groups where obtaining official statistics or comprehensive service data is a challenge. Examples include homeless people, gypsy and traveller communities, sex workers and asylum seekers and refugees, groups who may be less likely to register with a local GP. As GP consortia will also be

³⁰ The aim of the Government's NHS information revolution is to give people access to comprehensive, trustworthy and easy to understand information from a range of sources on all aspects of healthcare; the planned changes are outline in the White Paper, 'Equity and excellence: Liberating the NHS'. The Department will publish an information strategy in the near future to seek views on how best to implement these changes.

responsible for the unregistered population, it is important that they augment their quantitative data with community intelligence, working closely with local advocacy groups and their local HealthWatch to engage these seldom heard communities.

Partnerships

- A57. GP consortia will be expected to work closely with HealthWatch on embedding patient and public engagement in commissioning decisions. This relationship will be crucial when communicating to patients and the public how commissioning and service delivery will change at a local level. Evidence shows that where routes to accessing services seem complex and confused, this can potentially lead to increased attendance at A&E from vulnerable groups and newly arrived communities not fully conversant with the UK health system.
- A58. There is also a need to target messages to specific groups, given their previous experiences of accessing primary care. For example, Chinese, Pakistani and Bangladeshi communities' experiences of communicating with their GP are considerably and consistently worse than others. Lesbian, gay, bisexual and trans groups have experienced direct and indirect discrimination in the past from GPs and other primary care professionals, sometimes resulting in restricted access to both routine public health interventions (e.g. screening programmes) and specialist services.
- A59. The NHS Commissioning Board and GP consortia will have a duty to involve patients and the public in the planning of health services. As such, they could consider how best to utilise the community development expertise within the third sector, not only to communicate changing health and care arrangements but also to build trust and capacity to engage among certain community groups.
- A60. GP consortia will be obliged to become members of health and well-being boards (HWB) which will be committees of local authorities. Local authorities will be required to meet the general and specific duties of the Equality Act 2010, namely to eliminate discrimination, promote equality, and foster good relations between communities, in discharging their duties as a public body. Local authorities have a long history of developing and implementing equality strategies; their expertise could assist GP consortia in driving improvements in equality within healthcare.
- A61. Given the proposals to enhance its role as the NHS complaints advocacy service and support for individuals to exercise choice, Local HealthWatch should also seek to forge close professional relationships with local advocacy services that work with the most vulnerable and marginalised communities. The important role of these voluntary and community organisations should be acknowledged at a national level and their activity supported at a local level, potentially through partnerships with other local community groups, Local HealthWatch and health and well-being boards.
- A62. The Government's proposals for the specific public sector equality duties encourage organisations to embed equality and diversity within normal business planning processes. The

Department of Health is currently working with the NHS to develop a tool³¹ that will support commissioners and providers in achieving their equality outcomes, linking these clearly to health outcomes. As GP consortia will be encouraged to work closely with local authorities, alignment of the NHS tool with the equalities framework used across local government³² would be beneficial.

Workforce

- A63. The Government Equalities Office is considering its response to the recent consultation on the specific equality duties for public sector bodies. As most existing PCTs and SHAs employ more than 150 staff, it is proposed they will remain obliged to collect and annually publish workforce equality data. The Equality and Human Rights Commission will issue a more detailed Code of Practice and guidance in early 2011, and it is expected that data on ethnicity, disability and the gender pay gap will be required as a minimum. Should GP consortia contain fewer than 150 employees, there would be no such obligation to publish this data.
- A64. This would have a negative impact on protected groups in two ways. Firstly, without the obligation to publish data, collection may become less rigorous and data quality may deteriorate as a result. This would affect the ability of GP consortia to identify any patterns of inequality (or indeed improvements) in employment practices. This potential impact might be mitigated by the proposed requirement for all public bodies to publish 'a range of equality data relating both to their workforces and to the services they provide'³³, in line with the Public Sector Transparency Board's draft Public Data Principles. Secondly, it is important that, as part of ongoing measurement of the impacts of this policy on equality groups, the NHS is able to compare accurately the composition of the workforce before and after the transition.
- A65. Intelligence from recent staff surveys shows that there are ongoing inequalities in access to employment and progression opportunities, particularly for BME groups and women. Black staff are also less likely to feel that they have access to career opportunities. The inequalities experienced by Pakistani and Bangladeshi groups are of particular concern, as these groups also experience significant inequalities in other spheres, e.g. access to health services, health outcomes and key determinants of health. Trends in employment, progression and redundancy need to be carefully monitored through the transition to new commissioning arrangements to identify and rectify any emerging disparities.
- A66. Evidence also shows a strong association between employee and patient experience. This is supported by work carried out through the Social Partnership Forum, which found that higher levels of staff engagement resulted in higher patient satisfaction and a higher quality of service provision.³⁴ In implementing 'Commissioning for patients', there needs to be recognition of this relationship and its impact on high quality patient care and improved health outcomes. This is particularly important in organisations with higher percentages of disabled staff or employees

³¹ NHS Equality Delivery System

³² Equality Framework for Local Government - <http://www.idea.gov.uk/idk/core/page.do?pageld=9491107>

³³ Equality Act 2010: The public sector Equality Duty Promoting equality through transparency. http://www.equalities.gov.uk/news/specific_duties_consultation.aspx

³⁴ Social Partnership Forum response to 'Transparency in outcomes: a framework for the NHS'. The SPF brings together NHS Employers, NHS trade unions and the Department of Health (DH) to discuss, debate and involve partners in the development and implementation of the workforce implications of policy.

from BME groups, who tend to experience the highest levels of discrimination, bullying, harassment and abuse. Feedback from the NHS staff survey should continue to be analysed across the transition period, not only to monitor and address inequalities in staff experience but also as an 'early warning' indicator of possible trends in patient experience.

- A67. 'Commissioning for patients' proposes that GP consortia will have the flexibility to secure the support they require, in order to effectively carry out their commissioning function. If GP consortia choose to employ additional staff, it is important that they can evidence how their terms and conditions meet relevant employment legislation, including the provisions of the Equality Act 2010 that relate to equal pay. This is potentially an area where existing PCTs, working with GP consortia during the transition, can ensure that appropriate human resources knowledge, skills and tools are retained.

Overall Assessment of Impact

- A68. The Department has assessed the impact of the commissioning policy on equality generally, and considered its potential impacts on each of the protected characteristics, informed by any available evidence and feedback from the consultation process (see Table 1). The Department's view is that the steps outlined in Table 1, or the actions in section 7 can mitigate the potential negative impacts of the policy on each protected group, therefore our overall assessment of the commissioning policy is that a negative impact is unlikely. The policy has the potential to reduce barriers and inequalities that currently exist. However, there is not enough evidence to make this assessment with as much confidence as we would like.
- A69. There is a clear need for more robust evidence on the impact of commissioning on health outcomes; the lack of evidence in this area has been highlighted in this EIA. The forthcoming system changes present an ideal opportunity to build in robust and ongoing evaluation of commissioning, including the effectiveness of the new commissioning structure. The Department of Health plans to commission a five-year research project commencing in January, looking at the impacts of GP consortia commissioning strategies. It will address approaches taken to reduce health inequalities/inequities and through its longitudinal design will gather evidence of impact in these areas.
- A70. A common concern was that GP consortia would not have the knowledge and experience to commission services for more vulnerable and marginalised groups, resulting in a widening inequalities gap between those visible to GP commissioners and those who are not. Stakeholders need to be reassured that GP consortia will have access to the support and development they require to commission for the whole community, including seldom heard groups.
- A71. There are a number of important levers within the system, which, if utilised effectively, can strengthen and improve the ability of the NHS to further embed equality in commissioning to improve outcomes, e.g. local health and well-being boards (HWBs), Local HealthWatch, Commissioning Outcomes Framework. Explicitly articulating their individual roles in promoting equality would help ensure that it is hardwired into the everyday business of the NHS.
- A72. Effective commissioning requires good quality data, not only to inform needs assessments and service planning but also to empower patients and the public, allowing them to compare

commissioner and provider performance and make choices. The forthcoming Information Strategy will be critical in creating a consistent approach to data collection.

- A73. The evidence available on the potential impacts of change on protected groups within the NHS workforce indicates that BME employees, disabled staff and women are less likely to benefit from organisation change. This data in part reflects the current focus on workforce data collection within the NHS; evidence shows that datasets for age, ethnicity, gender and (to a lesser extent) disability are far more robust than that for other protected characteristics, such as sexual orientation and religion or belief. That said, impacts of the transition and new arrangements need to be closely monitored to ensure that all protected groups – as specified within the Equality Act 2010 - are not disproportionately negatively impacted

Recommended Actions

- A74. This EIA recommends actions for both policy development and practice.

- A75. Department of Health:

- Consider the effect of (a) areas of high deprivation and poor health outcomes; and (b) impacts on health outcomes due to third party improvements in the determinants of health in implementing the proposal for payments in respect of performance.
- As part of the forthcoming Information Strategy, develop a consistent approach to the collection of equalities data in line with forthcoming guidance on public sector equalities duties due in early 2011.
- Ensure that the forthcoming longitudinal research project on the impacts of GP consortia commissioning strategies includes an analysis of the impacts on protected groups and approaches taken to reduce health inequalities and promote equality.
- Work with health & well-being board early implementers and GP consortia pathfinders to consider and share the lessons on how their work can contribute to reducing inequalities and promoting equality.
- Seek to ensure that the final guidance for that may be published by the Board on the form and content of GP consortia proposed constitutions is available to patients and the public, and clearly explains the provision consortia may wish to make to guard against conflicts of interest.
- Ensure that the mandate for the NHS Commissioning Board sets out clear expectations on equality.

- A76. NHS Organisations and Health & Wellbeing Boards:

- Consider developing appropriate equality training and support for prospective GP consortia, linking it clearly to their role as commissioners. [NHS Commissioning Board]
- Where possible, align the emerging NHS Equality Delivery System with the existing Equality for Local Government Framework, to facilitate partnership working on equality and diversity and the development of joint equality outcomes where appropriate. [NHS Commissioning Board]

- Utilise community development expertise within the third sector to build trust and develop links with local communities, in order to facilitate their involvement in shaping and influencing commissioning decisions [GP consortia]
- Consider practical ways of supporting local third sector advocacy groups working with marginalised or seldom heard communities. [Local HealthWatch, working with Health & Well-being Boards]
- Monitor NHS workforce statistics throughout the transition period in order to highlight and mitigate any negative impacts on NHS staff from protected groups. [Initially Primary Care Trusts & Strategic Health Authorities; later NHS Commissioning Board & GP consortia]
- Work with local partners, including Local HealthWatch and advocacy groups, to promote choice among protected groups and disadvantaged communities. [GP consortia]

Table 1 : Potential Impacts on Protected Groups

The table below critically assesses the policy for its impacts on protected groups, together with proposed mitigating actions or opportunities where equality and diversity can be promoted.

Protected Characteristic	Potential Impacts Identified	Actions to Mitigate / Opportunities to Promote
Race	Insufficient knowledge of commissioning mental health services, an area where some BME groups experience entrenched inequalities	GP consortia can buy in support for commissioning in this area. NHS Commissioning Board's commissioning guidance can cover commissioning of these services. The Board, when issuing such guidance, will have a statutory duty to have regard to the need to reduce inequalities between patients with respect to their ability to access health services and the health outcomes achieved.
	Newly arrived communities may lack knowledge of new local arrangements for health services, resulting in increased attendances at A&E	GP consortia can work with Local HealthWatch, voluntary or local advocacy groups and local public sector organisations to ensure that these communities are aware of how to access local services e.g. through ensuring information is available in community languages
	BME groups who have expressed greatest dissatisfaction with GP services may feel less inclined to engage with health services	GP consortia can work with Local HealthWatch and local BME advocacy groups to build trust among specific BME communities and capacity to engage
	Certain smaller ethnic groups, such as gypsies and travellers experience stark inequalities. It may be difficult for GP consortia to source robust health intelligence about these communities, leading to inadequate needs assessment and inequities in service provision	Existing national research and intelligence on ethnic communities can be collated and made widely available to GP consortia, e.g. primary care service framework for Gypsies & Travellers ³⁵ . Local Joint Strategic Needs Assessments can be used to capture intelligence on seldom heard groups that is currently held by local authorities and voluntary organisations
	A higher percentage of GPs from BME	There is scope within GP consortia for individual GPs to have the

³⁵ http://www.pcc.nhs.uk/uploads/primary_care_service_frameworks/2009/ehrg_gypsies_and_travellers_pcsf_190509.pdf

Protected Characteristic	Potential Impacts Identified	Actions to Mitigate / Opportunities to Promote
	backgrounds work in single-handed, inner city practices. ^{36 37} This could result in less BME GPs being able to take an active role in commissioning due to existing workload	level of involvement in commissioning as suits their professional interests and personal circumstances. As public bodies, GP consortia will be subject to the duty in the Equality Act 2010 to advance equality of opportunity. GP consortia will have to set out in their constitution the arrangements made by it for the discharge of its functions. Guidance may be issued by the Board on the form and content of constitutions and could encourage involvement from underrepresented groups of GPs
	Lower paid workers and particular ethnic groups (e.g. Pakistani, Bangladeshi, Caribbean employees) might be disproportionately affected by forthcoming system changes	Good quality data now exists on the ethnicity of the NHS workforce by grade, which will allow trusts to monitor impacts by these characteristics throughout the transition period
Disability	Lack of robust disaggregated primary care data on disability of service users could lead to inadequate needs assessment and inequities in service provision	The NHS Commissioning Outcomes Framework will ensure that, where possible, outcomes are measured by equality characteristics so inequities between different groups can be identified and addressed
	GP consortia may promote the medical model of disability, rather than the social model preferred by disabled people	The new Equality Act 2010 is more closely aligned to the social model. As public bodies, GP consortia will be subject to the duty in the Act to advance equality of opportunity, therefore their activities will need to be aligned to the requirements of the Act.
	People with learning disabilities (PWLD) may not be sufficiently informed of the changes to the health and care system, resulting in poorer access to primary care services and increased	GP consortia can work with Local HealthWatch and local learning disability advocacy groups to build the capacity of PWLD to understand the changes and engage with health services

³⁶ Royal College of General Practitioners (2005) Inner City General Practice. *RCGP Information Sheet*. No.20 [online] http://www.rcgp.org.uk/pdf/ISS_INFO_20_JUL05.pdf Accessed 7 November 2010

³⁷ de Wilt G, Gill P, Chudley S and Heath I (2004) Racism in general practice: the time to turn a blind eye has passed. *The New Generalist*. Vol.2, No.1, pp.84-85

Protected Characteristic	Potential Impacts Identified	Actions to Mitigate / Opportunities to Promote
	attendance at A&E Deaf service users may not be made sufficiently aware of changes to commissioning arrangements, particularly as total numbers of Deaf services users within a single GP consortium might be small	GP consortia can work with Local HealthWatch and national and local third sector organisations (e.g. SignHealth ³⁸) to engage with and inform deaf service users
	Lack of regional specialised commissioning support may disproportionately impact on those with rare long-term conditions who relying on potentially life-saving interventions	All regional and national specialised commissioning will be carried out by the NHS Commissioning Board. National specialised commissioning will improve national consistency and ensure that best practice is more easily replicated. The Board will be looking at various models to ensure that whilst maintaining a coordinated national approach, it is also able to operate locally where required.
	Jointly commissioned services for people with mental health difficulties, physical disabilities and learning disabilities may suffer from a lack of local health commissioner input while relationships between consortia and local authorities are being established	GP consortia will have a power to enter into partnership arrangements with local authorities and other agencies to identify ways of providing more integrated delivery of health and social care During transition PCTs will have a role in ensuring that key knowledge and skills are transferred to GP consortia
Gender	Evidence suggests that men are less likely to exercise choice in selecting a GP, which may potentially restrict their access to more appropriate or better quality care	GP consortia can work with Local HealthWatch, voluntary organisations and public sector organisations to ensure that men have the information and support required to exercise choice NHS Choices could also be used to provide targeted health information for men and other population groups
	Female GPs may be less able to take a full and active role in GP commissioning due to greater proportion of women GPs working part-time or with caring responsibilities ³⁹	There is scope within GP consortia for individual GPs to have the level of involvement in commissioning as suits their professional interests and personal circumstances. As public bodies, GP consortia will be subject to the duty in the

³⁸ <http://www.signhealth.org.uk>

³⁹ Royal College of General Practitioners, op. cit.

Protected Characteristic	Potential Impacts Identified	Actions to Mitigate / Opportunities to Promote
		Equality Act 2010 to advance equality of opportunity. Guidance about the establishment of GP consortia could include suggested ways of working that encourages involvement from underrepresented groups of GPs
	Maternity services commissioned nationally may not be sufficiently aligned with postnatal and other related health services commissioned locally by GP consortia	Responsibility for commissioning maternity services now lies with GP consortia, but with a strong role for the Board in promoting quality improvement and extending choice for pregnant women.
Gender Reassignment	Trans people who have reported poor experiences in accessing GP services and referral to specialist services may have concerns about consortia commissioning health services on their behalf	The NHS Commissioning Board will have responsibility for commissioning specialised services, which includes gender identity services. GP consortia can use existing guidance, e-resources and intelligence held by national trans organisations to increase commissioner knowledge of trans issues and treatment options.
	Lack of data on trans service users, could lead to inadequate needs assessment and inequities in service provision	The Department of Health Equality and Inclusion Team will be working with the Equality and Human Rights Commission (EHRC) to help strengthen the evidence base on the health needs of trans people
Marriage and Civil Partnership	No specific potential impacts identified for married couples or those in civil partnerships	
Age	Insufficient knowledge of the range of services for vulnerable children, such as children in care, young refugees / asylum seekers and children with mental health problems	GP consortia will a power to enter in to partnership arrangements with local authorities (including children's services) and other strategic partners locally to gather relevant intelligence to commission appropriate services
	Older people may be less able or willing to exercise choice in selecting a GP, which may potentially restrict their access to more appropriate or better quality care	The NHS information revolution will ensure that comprehensive and accessible data and information will be available to patients, to enable them to make choices about their healthcare. GP consortia can work with Local HealthWatch and third sector

Protected Characteristic	Potential Impacts Identified	Actions to Mitigate / Opportunities to Promote
		advocacy groups to ensure older people are supported to exercise choice
	GP Commissioners may need additional support to fulfil their obligations around age discrimination in the Equalities Act 2010	The Department of Health Equality and Inclusion team will work with the emerging NHS Commissioning Board to gauge whether additional support is required for GP consortia in this area
	Jointly commissioned services for older people and children may suffer from a lack of local health commissioner input while relationships between consortia and local authorities are being established	GP consortia will have a power to enter into partnership arrangements with local authorities and other agencies to identify ways of providing more integrated delivery of health and social care During transition PCTs will have a role in ensuring that key knowledge and skills are transferred to GP consortia
	Older lesbians, gay men and bisexual people may be reluctant to approach health services as in the past, health professionals were those attempting to 'cure' their sexual orientation ⁴⁰	GP consortia can work with Local HealthWatch and local advocacy groups to build trust among older LGB communities and facilitate greater involvement.
Sexual Orientation	Lesbians, gay men and bisexual people who have reported poor experiences in accessing GP services may have concerns about consortia commissioning services on their behalf.	GP consortia can work with Local HealthWatch and local advocacy groups to build trust among LGB communities and facilitate greater involvement.
	Lack of data on LGB service users could lead to inadequate needs assessment and inequities in service provision	Existing national research and intelligence on these communities can be collated and made widely available to GP commissioners Local Joint Strategic Needs Assessments can be used to capture local intelligence on seldom heard groups currently held by local authorities and voluntary organisations The NHS Commissioning Outcomes Framework will ensure that, where possible, outcomes are measured by equality characteristics so inequities between different groups can be identified and addressed.

⁴⁰ Musingirami P (2008) Health Issues Affecting Older Gay, Lesbian and Bisexual People in the UK. London: The International Longevity Centre

Protected Characteristic	Potential Impacts Identified	Actions to Mitigate / Opportunities to Promote
Religion or Belief	GP consortia may lack specific knowledge of how to commission culturally appropriate care for particular religious groups	Existing guidance can be collated and easily available to GPs to inform their commissioning practice Engaging with religious communities and denominations (e.g. Muslims, Hindus etc.) can provide an effective way of targeting health messages or preventive services to certain ethnic groups NHS Commissioning Board's commissioning guidance can cover commissioning of these services. The Board, when issuing such guidance, will have a statutory duty to have regard to the need to reduce inequalities between patients with respect to their ability to access health services and the health outcomes achieved. The NHS Commissioning Outcomes Framework will ensure that, where possible, outcomes are measured by equality characteristics so inequities between different groups can be identified and addressed
Socio-economic Status	Lack of available data on chronically excluded and vulnerable groups, e.g. homeless people, could lead to inadequate assessment of health needs and insufficient service provision	Existing national research and intelligence on marginalised groups can be collated and made widely available to GP commissioners, e.g. Inclusion Health evidence pack (March 2010) ⁴¹
Workforce	The NHS may be unable to fully monitor the impacts of the transition on different staff groups due to lack of robust equalities data	The EHRC will be issuing a Code of Practice guidance to public bodies on data collection early in 2011, which should include minimum standards for data collection

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⁴¹ <http://umbr1.cabinetoffice.gov.uk/media/346574/inclusion-health-evidencepack.pdf>

Equality Impact Assessment:

Annex B: Liberating the NHS – Economic Regulation and Foundation Trust Liberalisation

Introduction

- B1. The White Paper, *'Equity and Excellence, Liberating the NHS'*⁴² sets out a number of policies designed to improve the healthcare system, with the aim of providing higher quality services that are more responsive to patient needs and more efficient.
- B2. The aim is for all providers of NHS services to be autonomous within a regulated market so they can respond to patient needs. Providers will have incentives to innovate to improve patient care to attract more patients.
- B3. To ensure the healthcare system operates efficiently the Government plans to develop Monitor (which is currently the independent regulator of FTs) into an economic regulator for all providers of health care and adult social care from April 2012. Monitor will be responsible for:
- **Promoting competition:** Monitor will have a duty to promote competition. It will also have powers concurrent with the Office of Fair Trading (OFT) in relation to anti-competitive behaviour and market investigations and powers to prevent anti-competitive behaviour by commissioners. The current responsibilities of the Cooperation and Competition Panel (CCP) will move into Monitor, creating an independent centre of excellence in competition.
 - **Issuing an economic licence to providers of NHS services in England alongside the Care Quality Commission's (CQC) quality licence (in a joint licensing regime):** An economic licence will be required for activity which involves or is connected with the provision of NHS health care. This is intended to contribute to achieving a fairer playing field for new entrants and current providers.
 - **Regulating prices:** Leading responsibility for certain aspects of the price setting process alongside the NHS Commissioning Board. Monitor will lead on the development of a pricing methodology and the price levels, with the Board leading on the services subject to national price controls and the pricing structure. Both parties will have to agree on these outputs.
 - **Supporting the continuity of services alongside commissioners:** The NHS Commissioning Board and commissioners will have primary responsibility for this. Monitor's role will be to produce guidance to aid classification and set conditions in provider licences to protect continuity of services under certain circumstances. A risk pool funded from a fee paid by providers and contingency arrangements will be introduced to protect services and the Department's budget in the event of provider failure.
- B4. Under these new arrangements, it will be important for Monitor to treat all providers even-handedly. Where controls on providers are needed, they will largely take effect through regulatory licensing and clinically-led commissioning. It will therefore be inappropriate for Monitor to retain in the long term its current special relationship with Foundation Trusts (FTs) under which it has powers and duties in relation to FTs' internal affairs that it does not have, and will not have, in relation to other providers. The Bill will therefore remove some of the current statutory controls exercised by Monitor that are specific to FTs, so that they are able to compete on more equal terms with other providers. As a corollary of this removal of FT-specific controls exercised by Monitor, steps are being taken to strengthen FTs' internal governance.

⁴²http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353

B5. Measures to strengthen FTs' internal governance include legislating:

- to clarify the role of FT governors (for example, by setting out new statutory duties for governors to hold the non-executive directors to account for the performance of the board of directors and to represent the interests of the FT membership and wider public)
- to clarify the duties of directors (including their individual and collective responsibility to promote the success of the FT to maximise benefits for its membership and the public)
- to give governors additional powers and responsibilities (e.g. in relation to mergers and constitutions).

B6. Measures to give FTs new autonomy include:

- **Removing the requirement for Monitor to approve changes to an FT's constitution.** Instead, there will be requirements for the FT's own directors, governors and, in certain circumstances, its members to agree changes to the FT's constitution.
- **Removing Monitor's power to set "terms of authorisation" for each FT, including:**
- **Removing the cap on the income from private patients that Foundation Trusts can earn.** However, the principal purpose of each FT will continue to be the provision of goods and services for the purposes of the health service in England; and
- **Removing the statutory borrowing limit set for each FT.** Instead, each FT will be subject to normal commercial borrowing constraints imposed by lenders.
- **Removing the requirement for Monitor to decide whether an FT may merge with another FT or acquire an NHS Trust** and introducing new flexibility, for example for an FT to acquire another FT or separate into two or more FTs. The decision on whether the merger or other organisational change should happen will be taken, not by Monitor as regulator of FTs, but by the FT itself (subject to meeting any requirements that would apply to providers more generally, such as those relating to competition issues).

B7. The governance arrangements for FTs already ensure that the public they serve and the staff they employ have a voice in how they are run. To ensure that all statutory NHS providers benefit from this and from the additional autonomy now proposed for FTs, the Bill sets a date when legislation relating to NHS Trusts will be repealed (April 2014). Beyond this date, it will not be an option for NHS Trusts to continue in existence (except in exceptional circumstances and on a purely transitional basis for trusts under franchised management contracts).

B8. Following transition, the Secretary of State for Health (SofS) will have a more limited direct relationship with the provider side beyond his role in setting the legislative framework. His relationship with the NHS will be conducted primarily through the process of setting the mandate for the NHS Commissioning Board, which will be subject to the public sector equality duty described (in paragraph B10) below. He will have the power to set an annual mandate that the NHS CB will have to comply with, including instructions/directions to support the delivery of the mandate. The mandate will set out the totality of what the Government expects from the NHS CB on behalf of the taxpayer for that period.

Relevance to Equality and Diversity

B9. The purpose of this equality impact assessment (EIA) is to inform development of this policy so that, as far as possible, it:

- i. Eliminates discrimination and does not generate or exacerbate inequalities in access to healthcare or health outcomes for patients and the public or employment and progression opportunities for actual/potential employees;
- ii. Supports local efforts to reduce inequalities, promote equality and foster good relations between people from protected groups and those who are not.

B10. In carrying out this assessment, we have considered the following dimensions:

- Age
- Disability
- Gender reassignment
- Pregnancy and maternity
- Race or ethnicity
- Religion or belief
- Sex
- Sexual orientation
- Socio-economic status

B11. We have chosen to include all the relevant protected characteristics covered by the Equality Act in accordance with good practice guidance from the Equalities and Human Rights Commission (EHRC). Not all the provisions of the Equality Act are yet in force; some, such as the prohibition on age discrimination in services and public functions are still under consideration, and the public sector equality duty is due to commence in April 2011. Our consideration of these characteristics takes into account that we expect these measures to be in force when these provisions come into effect.

B12. Socio-economic status is not one of the protected characteristics that must be covered in the public sector equality duty and therefore in the EIA, but has been included for completeness of impact on current health inequalities.

B13. The change in regime will impact upon all those providing services for NHS patients and employing staff to provide such services, and on NHS patients and service users too. Service provision and employment are both areas in which the ban on discrimination in the Equality Act 2010 applies. In addition, the provision of NHS services is a function of a public nature and therefore a function to which the Public Sector Equality Duty created by section 149 of the Equality Act 2010 applies. This duty requires those exercising the function to have due regard to the need to: a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Act; b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not; and c) foster good relations between persons who share a relevant protected characteristic and persons who do not.

The Equality Act 2010 and Powers of the Secretary of State

B14. The Equality Act aims to simplify, harmonise and strengthen equality law, replacing nine major pieces of legislation and around 100 other instruments with a single Act. It received Royal Assent on 8 April 2010. The main provisions in the Act came into force in October 2010 and the single public sector equality duty will come into force in April 2011⁴³.

⁴³ From April 2012, the ban on age discrimination in provision of goods, facilities, services and public functions will be implemented.

- B15. The single public sector equality duty covers race, disability, and gender (existing duties), plus age, sexual orientation, religion or belief, pregnancy and maternity, and gender reassignment. These dimensions are collectively referred to as the protected characteristics. All public bodies, including those changed or set up through these provisions, must have due regard to the need to:
- eliminate unlawful discrimination, harassment, and victimisation;
 - advance equality of opportunity; and
 - foster good relations between those who share a relevant protected characteristic and those who do not.
- B16. This general duty is underpinned by specific duties, to help public bodies meet the general duty. The Government has recently undertaken a public consultation on the specific duties.
- B17. The Equality Act 2010 will ensure that all public bodies within the health service, including the NHS and the public health service, are obliged to comply with principles of equality. This will include those bodies established under the Bill, such as GP consortia, and those whose functions are changed, such as some of the arm's-length bodies (CQC, NICE and Monitor). These duties also apply to private providers in so far as they are providing NHS services, on the basis that the provision of services for the purposes of the health service is a function of a public nature. This can be brought about by measures such as the inclusion of contractual terms relating to equality in contracts with such organisations, where this is considered necessary.

Summary of Evidence

- B18. This EIA relies on evidence and stakeholder feedback to:
- provide supporting evidence where actual or potential impacts on equality and human rights were identified
 - assist with developing proposals for mitigating potential negative impacts
 - demonstrate how proposed reforms can promote equality and human rights, where possible
- B19. This section summarises available evidence relating to equality issues relevant to regulatory functions and liberalisation of FTs. It aims to cover as many issues as possible pertaining to the protected equality groups.

Promoting Competition

- B20. The benefits of competition have not been systemic across the NHS because of barriers to the operation of markets.⁴⁴ Introducing a social market should help competition to develop across more services and geographical areas and services to be better tailored to the needs of patients, including specialist services for those with protected characteristics.
- B21. The Civitas Report⁴⁵ suggests that improvements in healthcare are associated with increasing competition among providers. It also highlights that competition is currently not systemic across the NHS, so there is unequal access to the benefits that competition provides.

⁴⁴ Brereton L, Gubb J. *Civitas Report 2010 - Refusing Treatment: The NHS and market-based reform*. Bertfords Group Limited

⁴⁵ Brereton L, Gubb J. *Civitas Report 2010 - Refusing Treatment: The NHS and market-based reform*. Bertfords Group Limited

B22. There is evidence to suggest that there may be a risk that it could take more time for the benefits of competition and regulation to impact upon poorer areas, which could result in an adverse effect on certain groups:

- *The Marmot Review 2010*⁴⁶ explains the significance of socio-demographic inequalities in healthcare. This highlights Monitor's role in raising the baseline of healthcare quality in areas where the benefits of competition are yet to reach.
- *Gaynor et al (2010)* found competition impacted differently across certain areas with possible negative impacts on transgender and black and minority ethnic (BME) people⁴⁷.

B23. However, further evidence implies that these risks, associated with increasing competition, should not be overstated and may not impact upon equality issues. This is discussed further in section e.

- *Cookson et al (working draft)*⁴⁸ found that increasing competition in the NHS between 2003 and 2008 did not undermine socio-economic equity in hospital care and if anything may have slightly increased utilisation of elective inpatient care in deprived communities.
- Preliminary findings from the DH commissioned Health Reform Evaluation programme⁴⁹ show that the impact of further market reforms on equity of access to the provider market of 2001/2 to 2007/8 did not impact upon equity adversely.

Joint Licensing Regime

B24. Currently, there is no economic licence for healthcare providers. Commissioners may assess economic viability differently, so in one area a provider may be considered to be economically viable, whereas on alternative assessment criteria used in another area, the same provider maybe judged unviable. This makes expansion of service provision across geographical areas more difficult and could stifle competition in some markets. This results in the benefits of competition not being achieved in some areas, reducing the quality of service offered to patients in these areas, including those with protected characteristics.

B25. The CQC is a Non-Departmental Government Body that issues a quality licence for all providers. It has a duty as a public body to monitor and report on how well both individual providers and the health and social care sector as a whole are advancing equality. This duty will continue in the new joint licensing regime, so will not need to be duplicated by the economic licence.

Regulating Prices

B26. The tariff covers the average cost of providing a service but there are large differences in costs across the country (e.g. because of variations in input costs). Equality issues could arise as there could be an increase in competition in the markets with costs at the low-end of the spectrum, with the high cost areas receiving no increase in competition. This can impact upon equality as higher cost tailored services for specific patient groups are sometimes not reflected in the price.

⁴⁶ Marmot M, February 2010. *The Marmot Review: Fair Society, Healthy Lives.*, p16

⁴⁷ Gaynor M, Moreno-Serra R, Propper C, (July 2010) *Death by Market Power Reform, Competition and Patient Outcomes in the National Health Service*. NBER Working Paper No. 16164, July 2010.

⁴⁸ Cookson et al (2010) *Competition and Inequality: Evidence from the English National Health Service 1991–2001*, *Jnl. of Public Admin. Research and Theory* 20(2) 181-205

⁴⁹ Preliminary findings from the DH commissioned Health Reform Evaluation programme (2010): Cookson et al - *Effects of health reform on health care inequalities*

- B27. The market forces factor⁵⁰ (MFF) adjusts for unavoidable costs to providers (e.g. land) but at present there are only small adjustments (additional payments for patients with complications and co-morbidities) to reflect the additional costs of providing services to populations with different characteristics.
- B28. The payment by results policy (or “PbR”) as set out in *Regulating Prices for Patient Choice Services and Natural Monopoly Services – Payment by Results (PbR) Equality Impact Assessment* is relevant to the proposals for pricing. The evidence explains the potential of an expanded pricing regime to reduce health inequalities (specifically in relation to age, disability and race, and for carers and mental health patients).

Supporting Service Continuity

- B29. Currently, the responsibility to ensure that essential services are maintained within a particular area falls to commissioners, with the Unsustainable Provider Regime (UPR) providing a failure regime with financial help for Foundation Trusts and NHS trusts. NHS organisations have access to the UPR, whereas private providers do not. This blunts incentives for commissioners to encourage cost-saving efficiency on the part of NHS Trusts and FTs, as the cost of their failure ultimately falls on DH’s budget. In addition, because it is more risky for non-NHS providers to provide NHS services (because they are not able to access central financial support), it discourages them from entering the market and so reduces the benefits that can be achieved through competition. Some voluntary sector providers provide targeted services for minority groups who may be disproportionately disadvantaged by the current system. Some of their particular needs are evidenced in the evidence base to the overarching equality impact assessment.
- B30. DEFRA conducted an impact assessment on the introduction of a special administration regime (SAR) for the water industry. They decided not to conduct an equality impact assessment, as it was not expected to raise any equality issues. The equality impact assessment was not required as the SAR would act as a safeguard to all consumers equally left vulnerable in the event that a provider has financial difficulties.⁵¹ We concluded that a separate equality impact assessment was not required for the introduction of the SAR in healthcare; however, possible impacts on equality issues are discussed in paragraphs 78-80.

Choice

- B31. The policies on regulation and FT liberalisation should act as an enabler of choice policy. In the longer term, we expect the choice on offer to patients to be improved as a result of these policies. There was an Initial Choice Equality Impact Assessment undertaken, which reviews the impact of choice on equality issues in detail.⁵²

⁵⁰ Market forces factor: The weighted capitation formula which determines NHS funding takes account of the fact that the cost of providing healthcare is not the same everywhere because of the impact of market forces on local costs (in other words, £1 of health expenditure buys different amounts of equal quality care in different parts of the country). The purpose of the MFF is to equalise the commissioning power of different bodies by adjusting for unavoidable variations in NHS trusts’ costs which are directly related to location.

⁵¹ <http://www.defra.gov.uk/environment/flooding/documents/policy/fwmb/fwmiaregime-waterind.pdf>

⁵² Liberating the NHS: Greater Choice and Control. Initial Equality Impact Assessment
http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_119651

NHS providers

B32. Evidence specific to the equality impacts of the proposed adaptations to the regime for NHS providers, as opposed to the advantages of competition in the wider provider landscape, is limited. In future, all NHS provision would be by foundation trusts and FTs, unlike NHS trusts, have to involve the public and staff in their governance. A study by the Healthcare Commission in 2005 noted that few FTs took specific action to involve groups of the population who were traditionally under-represented. It also noted that turnout for elections of governors varied widely: from 19% to 67% for public constituencies and 31% to 70% for patient constituencies. *Day and Klein (2005)* noted that there was limited evidence on the diversity of governors, but women appeared to be under-represented and a high proportion of elected governors were retired. *Ham and Hunt (2008)* concluded that governance arrangements in FTs were becoming more effective, but there was still untapped potential in creating a different relationship between FTs and the communities they served. The study looked at various models of FT governance that were emerging. Their conclusions included that there was a need to develop the most effective ways of governors engaging with the FTs' membership and for trust chairs to be able to relate effectively to the membership through the governors.

Delivering the FT Pipeline

B33. There appears to be some correlation between FT status (as opposed to NHS Trust status) and the delivery of a higher quality of care, although it is unclear to what extent this is a result of the FT model. The 2008/9 CQC Performance Ratings of Acute, Specialist and Mental Health care providers⁵³ assessed 240 organisations of which just under half were FTs⁵⁴. 55 were rated as 'Excellent' for overall quality score of which 37 were FTs (67%). Of the 13 providers rated 'Weak', 10 were NHS Trusts (77%).

B34. The policy of getting all NHS Trusts to FT status is therefore important for the contribution it can make to ensuring that the healthcare standards delivered by many FTs are available to all users of NHS provision in England. The delivery of the remaining NHS Trusts to FT status by April 2014 should help to ensure that this is achieved. The Government has decided to establish a transitional Provider Development Authority to provide dedicated expertise to support Trusts preparing for FT status. The Authority will continue in this role until 31 March 2014, and will be wound up when NHS Trust legislation is repealed.

Statutory controls on FTs

B35. The statutory controls that currently apply to FTs mean that they are not always able to respond as flexibly as they might to meet the diverse needs of commissioners and patients in their local area and beyond. The following paragraphs consider three particular examples of such controls.

Private Income

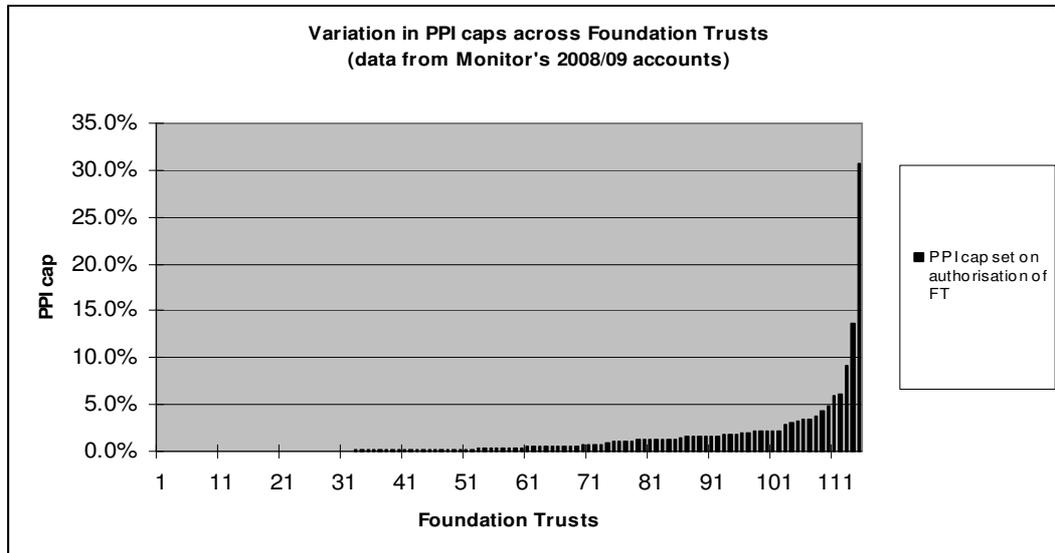
B36. The private patient income (PPI) cap limits the amount of income that an FT can generate from direct work with private patients, overseas patients and from joint ventures and partnerships. The PPI cap is set individually for each FT based upon the proportion of private income (as a

⁵³ Care Quality Commission: [NHS performance ratings 2008/09 - An overview of the performance of NHS trusts in England](#)

⁵⁴ At this time there were 240 organisations assessed for the year end 31 March 2009. 115 (48%) were FTs

percentage of total income) that the FT earned in the financial year 2002/03⁵⁵ irrespective of when the NHS Trust became a Foundation Trust. This results in arbitrary differences in the extent to which FTs can undertake private work (see Figure 1 below) with the majority of caps sitting below 1.5%, some around 5% and a few at higher levels such as 14% and 31%.

Figure 1: Variation in the level of PPI caps across Foundation Trusts (2008/09)



B37. This variation can, for example, be observed regionally with London having an average PPI cap of 4.6% compared with 0.3% for the North East (see Figure 2 below). The removal of the cap would do away with this varying restriction, while still leaving in place for each FT its principal purpose of providing goods and services for the health service in England. In addition, perverse consequences of the cap include the constraints it puts on the ability of the NHS to exploit the power of its brand abroad, and the pressure it creates to resist the decommissioning of unnecessary/inefficient NHS services, simply to avoid breaching the cap.

Figure 2: Variation in the average level of FTs' PPI caps across regions (2008/09)

Region	Average PPI cap across FTs within the region
London	4.6%
West Midlands	1.2%
East of England	1.2%
South East Coast	1.0%
South West	1.0%
South Central	1.0%
North West	0.9%
East Midlands	0.8%
Yorkshire and the Humber	0.7%
North East	0.3%

⁵⁵ If the trust was not in existence in 2002/03, the cap is based on the financial year immediately before it became a foundation trust.

Finance

B38. Under the current system, Monitor has a power to impose borrowing limits on FTs through the application of a Prudential Borrowing Code (PBC). Under the proposed new financing system, Monitor would no longer have the power to impose statutory borrowing limits on FTs. Instead, creditors, including the operationally-independent DH banking function, acting as guardian of taxpayers' investment, would protect their investment more directly, through conditions relating to the debt. It will be for FTs and their existing and prospective lenders to determine the level of borrowing appropriate to each FT.

Mergers, Acquisitions and Separations

B39. Foundation Trusts currently have to obtain Monitor's approval in order to merge or to acquire an NHS Trust and their restrictive legislative regime means they are not currently able to separate into two or more FTs or to acquire another FT. These arrangements can make it harder for FTs to re-organise themselves, even where such a change would be in the interests of meeting the healthcare requirements of their local populations. Replacing the current FT-specific constraints with controls that apply to all providers (linked, for example, to protecting services designated for additional regulation) and allowing acquisitions and separations will mean that FTs – like other providers – have autonomy to organise themselves appropriately with the potential to improve the way they meet local needs.

Governance

B40. Monitor currently has to satisfy itself that an applicant for FT status has taken steps to ensure that the public constituency of the membership (and the patient constituency, if it is proposed that the FT will have one) are representative. FTs also have to include in their annual reports information about the steps they have taken to ensure that the public constituency (and patient constituency if there is one) are representative. However, there is evidence that some groups are under-represented in the (active) memberships of FTs and amongst their governors (see paragraph B32 above).

General

B41. We have undertaken a review of evidence relating to the impact of independent economic regulation and FT liberalisation on all the protected characteristics covered by the public sector equality duty. Unfortunately, we were unable to find any specific evidence relating to religion or belief, or sexual orientation. Actions to increase the evidence base in the future in these areas may be considered, however this would be a decision for the NHS Commissioning Board and/or Monitor in the future.

Summary of Stakeholder Feedback

B42. Consultation on 'Regulating Healthcare Providers'⁵⁶ took place from July 26 to 11 October 2010. This section summarises points made in responses to the consultation, which we have used to inform the discussion in the 'Discussion of Potential Impacts' and 'Recommended Actions' sections of this equality impact assessment.

⁵⁶ Available at: http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH_117461

Consultation Written Feedback

Risks of Competition

B43. Some respondents thought the introduction of a competitive market in healthcare carried substantial risks. They feared that health inequalities could be widened as a result of increasing competition. For example, they thought that minority communities and less common illnesses might be less likely to be prioritised if commissioners were constrained by law to choose the most competitive provider. They were also concerned that certain hospitals in deprived areas might be visited only by those who did not have the capacity to travel elsewhere (such as disabled, older and/or less mobile patients) while more mobile patients would be able to travel and choose better hospitals.

Licensing

B44. Some responses suggested that additional licensing requirements could be used to ensure equity of access and provision. Some suggested that Monitor's mandate to promote economic efficiency should be expanded to include better serving patients, or that the Regulator might specifically assess the equality and diversity practices of organisations before granting an economic licence.

Information

B45. A number of responses argued for a requirement to collect data on access to healthcare for people with protected characteristics. They thought that this would ensure that there is evidence in the future to determine whether providers are offering equal access to their services. They suggested that there might be a statutory requirement on Monitor to produce regular equality and diversity reports. This could provide outcome profiles for different demographic groups and workforce demographic profiles to evidence progress against discrimination in employment and equity in service provision.

Issues that may affect staff

B46. A few responses suggested that providers should be required to publish annual equality profiles of their workforce and patients treated. This would provide information to tackle discrimination and barriers to career progression and provision of services to workers and patients with protected characteristics.

B47. Some responses expressed concerns about the impact of the reforms on staff. They feared that the increased freedoms proposed might allow providers to discriminate in employment or provision of services and therefore disadvantage minority populations and other staff groups. Equality issues relating to staff are discussed in paragraphs B81-B82.

Foundation Trusts

Private Income

B48. Some of those who responded to the consultation were concerned that removing the private income cap that currently applies to FTs would mean that private patients (who are likely to have higher incomes and higher socio-economic status and more likely to be middle-aged)⁵⁷ could be

⁵⁷ *The demand for private medical insurance*, Economic Trends 606, May 2004, Office for National Statistics

prioritised over NHS patients, resulting in increased waiting times for NHS patients and thereby increased inequalities between NHS and private patients. There were particular concerns that older people might be perceived as of lower priority and would be at risk of waiting longer for elective care. A number of safeguards against this risk were suggested including the following:

- Introduce an enforceable and demonstrable measure to ensure that FTs reinvest their income from non-NHS sources to improve NHS services or that an FT's non-NHS activities do not interfere with its principal purpose and public duties to NHS patients
- This could be achieved through more public accountability reporting of NHS versus non-NHS income activity and the publication of all FT patient outcomes to evidence any inequalities between private and NHS patient care

Finance

B49. On removal of the statutory borrowing limits for FTs, there were suggestions that an FT could be weakened by unsustainable borrowing and thus vulnerable to financial failure or a predatory take over, leading to a loss of local services. Local services were considered to be particularly important for older people and those in rural areas.

Merging, Acquiring and Separations

B50. One theme from the consultation was that the current arrangements for FT mergers can be cumbersome and bureaucratic and that removal of barriers to mergers to allow FTs to adapt to patient demographics and medical innovation would make sense financially and in terms of providing the diverse services patients want and need.

B51. Some responses specifically considered the proposals to give FTs flexibility to merge, separate, or acquire another FT or NHS trust. Some respondents felt that successful FTs may be reluctant to take over trusts that are failing and that struggling FTs may amalgamate, with the potential that this could create unnatural geographical boundaries that do not reflect the needs of patients.

B52. Some respondents wanted clearly demonstrated consent of staff and public before takeovers were allowed. They suggested this would guard against a trend towards fewer but larger hospitals which could disadvantage users with poor travel options and offer a less positive experience, for example in maternity services.

Governance

B53. Several stakeholders felt it important that Monitor maintain some say over the constitution of FTs to prevent disregard of the NHS core values and to prevent the organisation becoming dominated by a specific code of belief. They were concerned that "faith hospitals" might deny care to lesbian, gay, bisexual and transgender patients or employment to LGBT staff.

B54. Other respondents thought that changes to governance would need to ensure attention to the needs not only of local patients, but also of patients accessing specialised services who travel from a much wider catchment area. They thought these patients should have a right to representation equal to that of local populations.

B55. Respondents also felt that Foundation Trusts should have significant patient and carer representation in their governance structure.

General

- B56. Some respondents were concerned that discrimination could grow with the increased freedoms offered to FTs. They suggested that FTs should be required to publish annual equality profiles of both their workforce and for different demographic groups amongst their population, and show progress in reducing inequality in service provision. It was suggested that Monitor should work with providers to see how gaps in provision could be addressed.
- B57. There was concern that expanding the freedoms of providers may compromise patients perceived as lower value in the search for profit. Responses cited the comparators of energy, telecoms and financial services. This was similar to further concern that FTs could be reluctant to develop, or be able to secure capital for, services that are complex, expensive and only address a small patient community.

Stakeholder Consultation Event

- B58. A consultation event was held by DH on 30 September 2010 to discuss the impact of the White Paper. It included stakeholders from across the NHS, social care and voluntary and charitable sectors, as set out below:

Action for Prisoners' Families	National LGBT Partnership
Age UK	National Association for Voluntary Community Action
Brap	Naz Project London
British Red Cross	National Children's Bureau
Carers UK	National Centre for Independent Living
Combat Stress	NHS Bradford and Airedale
Diabetes UK	NHS Newham
Faithaction	NHS South West
Friends, Families and Travellers	Race Equality Foundation
Gender Identity Research and Education Society	Race for Health
Leeds Gypsy and Traveller Exchange	Royal College of General Practitioners
Leicestershire Partnership NHS Trust	Regional Voices
London Friend	Royal National Institute for the Deaf
Men's Health Forum	Royal British Legion
Mencap	Surrey and Borders Partnership NHS Foundation Trust
Mental Health Providers Forum	The Afiya Trust
NACRO	Voice4Change, England

- B59. The main concern raised was that economic regulation should be designed to reflect the different capabilities of organisations. For example, whilst FTs, private sector hospitals and national charities have a strong capability in responding to tenders, smaller organisations that offer services tailored to the needs of particularly vulnerable groups may not have such skills or resources. The framework of regulation needs to recognise this and support smaller organisations in bidding for contracts with GP consortia.
- B60. Other concerns expressed were around ensuring commissioners have the right incentives to ensure equality and diversity in their health care service provision.

Discussion of Potential Impacts

- B61. The new policy aims to enhance the stronger aspects of the current FT and regulation regime, improve on the weaknesses and mitigate any new risks that may arise.

Promoting Competition

- B62. The Civitas report⁵⁸ suggests that the introduction of Monitor as a regulator and liberalising FTs will offer opportunities to improve quality, efficiency, innovation and patient-focus in areas where a competitive market is able to develop. This is supported by a large body of evidence explained in the Impact Assessment.
- B63. However, as noted in paragraph B43, some consultation responses highlighted the possibility that increasing competition could result in increasing inequality, particularly in poorer or more isolated areas where the benefits of competition may not be realised.
- B64. Furthermore, Gaynor et al (2010) found that competition impacted differently across certain geographical areas (rural versus urban; unconcentrated provider landscape versus concentrated providers)⁵⁹. This could have effects on geographical equality of healthcare provision. For example, transgender people were more likely to live in rural areas (despite variability of prevalence)⁶⁰, so there was a risk that they would not receive the benefits of competition as rural areas are more likely to be served by fewer providers.
- B65. It is important not to overstate this risk. Recent research (Cookson et al 2010) looks into the NHS reforms between 1991 and 1997. They compare year-by-year inequality differences between areas with “potentially competitive” and “non-competitive” local hospital markets, as competition was phased in and out. They found no evidence to suggest that competition had any effect on socioeconomic health care inequality⁶¹, which remains a possible outcome of these reforms.
- B66. Additionally, preliminary findings from the DH commissioned Health Reform Evaluation programme⁶² suggest that the impact of further market reforms on equity of access to the provider market of 2001/2 to 2007/8 are that overall, markets are not bad for equity, and some

⁵⁸ Brereton L, Gubb J. *Civitas Report 2010 - Refusing Treatment: The NHS and market-based reform*. Bertfords Group Limited

⁵⁹ Gaynor M, Moreno-Serra R, Propper C, (July 2010) *Death by Market Power Reform, Competition and Patient Outcomes in the National Health Service*. NBER Working Paper No. 16164, July 2010.

⁶⁰ Gender Identity Research and Education Society (June 2010) *Gender Variance in the UK*

⁶¹ Cookson et al (2010) *Competition and Inequality: Evidence from the English National Health Service 1991–2001*, *Jnl. of Public Admin. Research and Theory* 20(2) 181-205

⁶² Preliminary findings from the DH commissioned Health Reform Evaluation programme (2010): Cookson et al - *Effects of health reform on health care inequalities*

indications are positive as healthcare reaches areas that it did not reach before. However, work is needed to confirm and corroborate these findings.

- B67. Nevertheless, the Bill aims to ensure that Monitor will have powers to promote competition where monopoly providers serve a more socially deprived area, so the best possible provider gains control over services. Monitor will have statutory responsibilities to promote competition and to carry out regulation, and will be bound by the public sector equality duty created by the Equality Act.
- B68. Moreover, the equality issues raised must be addressed, not only by Monitor, but also by providers and commissioners. As regards providers, the promotion of competition, alongside the expansion of any willing provider and the powers for Monitor to increase tendering for healthcare services, creates an opportunity for the healthcare system to advance equality. For example, providers of services targeted at populations with particular protected characteristics (e.g. sexual orientation, religion or belief, or gender) or located in a particular part of the country can deliver and expand the service to more patients.
- B69. Commissioners will be the largest mitigating factor against inequalities for patients with these protected characteristics, and all other circumstances that may lead to inequalities. One of their primary responsibilities as the purchasers of healthcare services for their local population will be to ensure adequate and timely availability of all services for their patients. This should include special provisions where particular services may be inaccessible by particular population cohorts.
- B70. There is a lack of evidence for the likely impact on sexual orientation, pregnancy or maternity, sex and religion and belief, though potential impacts are highlighted in Table 1. As this is a whole system change, designed to make the benefits of competition more systematic across healthcare, these groups are unlikely to be excluded from experiencing these general benefits. There are a number of safeguards in place to ensure that providers offer NHS patients care whatever the protected characteristics they have or do not have. Some of the responses to the consultation expressed concern that the new regime would permit providers to discriminate against patients and/or staff. It is important to make clear that this is not the case: the requirements of the Equality Act 2010, including its ban on discrimination in service provision and employment and the public sector equality duty that it creates, will remain in place.

Joint Licensing Regime

- B71. The Care Quality Commission (CQC) and Monitor will retain separate responsibility and powers for decisions about issuing, cancelling or revoking registration and licences, licence conditions, and enforcement. Our intention is to create a single integrated process and interface for providers and the Bill includes a duty for the two regulators to work together to achieve this.
- B72. As noted in paragraph B44, some consultation responses suggested that the economic licence could be used to collect information in relation to equality issues. Monitor's licence will focus on collecting data to inform pricing, competition policy and service continuity, and it will not have a specific remit to collect data on equality issues from a service user perspective. This responsibility will continue to lie with the CQC generally, but not necessarily as a condition of the quality licence.
- B73. We expect that the economic licence will contribute to significant improvements in the healthcare system. Once a licence has been obtained, it will be easier for those providers wishing to expand

to demonstrate their ability to provide services in other areas. This will signal that there will be a fairer playing field for all providers, enhancing competition and allowing market entry for any willing provider. The increase in competition will contribute to a wider choice of services for patients, better tailored to their needs. For example, under the introduction of any willing provider and a fairer playing field, a provider of services for older patients or populations with certain religious beliefs may find it easier to expand geographically once they have an economic licence.

Regulating Prices

B74. Monitor will become an independent centre of excellence in price setting, building on the work currently undertaken by the DH, which will include an accountable and transparent process. The function will also improve price setting and expand to cover more services. Monitor will be responsible for setting the price methodology and price levels, so in undertaking these tasks it must have regard to its duty to promote competition, where appropriate, and protect essential service delivery.

B75. The new arrangements will:

- a. Strengthen the building blocks of price setting
 - Some HRGs⁶³ are split to recognise additional costs that are associated with complications and comorbidities, problems commonly associated with older and disabled patients. The NHS Information Centre (IC) has implemented the comorbidity splits for each chapter in HRG4, which are based on a set of principles such as “minor degree has lower rank than severe degree”, but also takes into consideration the effect of complications and comorbidities on length of stay. This should have a positive impact on older and disabled patients as the cost of treating complications and comorbidities becomes more accurately reflected in the building blocks of price setting.
 - Development of patient level information and costing systems⁶⁴ (PLICS) will make cost data more transparent and therefore more accountable. PLICS should also facilitate the development of tariffs, through the provision of more detailed data. PLICS is a relatively new concept to the NHS and the data quality will need to be adequate before deciding on the extent of its use in these areas. Increased transparency and accountability will make monitoring equality issues easier in the future.
 - International Classification of Diseases (ICD) codes are used to help develop HRG codes to inform tariff levels. The NHS IC are implementing an update to the codes (expected to be published in April 2011) to reflect the most up-to-date international system, to aid the tariff in further reflecting different patient needs. For example, if increased costs associated with treating patients with more resource-intensive needs, are accurately reflected in the payment to those delivering the treatment, more providers will have the incentive to offer these services as their additional costs will be covered.

⁶³ HRGs (Healthcare Resource Groups) are the unit of payment, or currency, for the tariff. HRGs are clinically meaningful groups of diagnoses and procedures that consume similar levels of NHS resources.

⁶⁴ Patient-level information and costing systems can be defined by the ability to measure the resources consumed by individual patients. Patient-level costs are calculated by tracing resources actually used by a patient and the associated costs by using actual costs incurred by the organisation in providing a service or event. This process is facilitated through having integrated information systems from across the organisation. PLICS can reveal variations from average cost and provide a focus for clinical discussion about how to promote the adoption of more successful and cost effective clinical outcomes.

- b. Increase the scope and flexibility of national tariff
 - Pricing will expand its scope to include mental health services. Mental health service users are some of the most vulnerable in society. This will help to safeguard healthcare spending for these individuals.
 - A disproportionate number of mental health service users come from the black and minority ethnic (BME) population. The pioneers of the mental health currency work commissioned an equality study⁶⁵ of their methodology to check that it does not disadvantage BME service users. This study, carried out by the organisation brap⁶⁶, concluded that the methodology is sound from an equality perspective.

- c. Increase the accuracy of price setting
 - More accurate price setting should act as a safeguard to patients against ‘cream-skimming’ within a service by providers. “Cream-skimming” exists when some patients (e.g. those with comorbidities – often older and/or disabled patients) are refused treatment by a provider, as they can gain greater profits from treating only patients with no comorbidities. This risk is currently mitigated in the acute contract and improving the accuracy of price setting should reduce the incentives to ‘cream-skin’, increasing access to services for vulnerable groups.

- d. Improving the Market Forces Factor (MFF)
 - Monitor will be responsible for setting and improving the MFF. This should work towards creating a fairer playing field, by more accurately reimbursing NHS Trusts to reflect unavoidable costs (e.g. staff, land). This should work towards equalising the commissioning power of different bodies, so they can provide a better healthcare offer to patients, including those with protected characteristics.

Supporting Service Continuity

- B76. Primary responsibility for ensuring the continuity of services will lie with the new independent NHS Commissioning Board and GP commissioning consortia. Monitor may also need to intervene to ensure continued access to key services in some limited circumstances. In conjunction with commissioners, services that require protection will be classified as ‘services subject to additional regulation’ and conditions in providers’ licences will be set to protect the continuity of those services. This will provide a safeguard to patients to ensure they receive access to services, which could be especially important for patients with specialist needs or those living in a remote location.
- B77. We propose that a risk pool will be created by Monitor requiring all providers of ‘services subject to additional regulation’ to pay a levy. Introduction of the risk pool will act as an enabler towards the realisation of any willing provider by reducing barriers to entry (as all organisations have the same incentive to be economically viable) and improvements of the NHS offer to patients through more systematic increases in competition. It will also act as a safeguard by ensuring the continued provision of services subject to additional regulation in the event that a provider becomes insolvent.

⁶⁵ HoNOS and SARN Equality Impact Assessment - looking into making the report available on the website in the future

⁶⁶ brap is a registered charity (England and Wales) who aim to make a sustainable difference by working with others to better understand how practice might be improved in ways that reduce inequality

- B78. Special administration regimes (SAR) already exist in various sectors, for example in the water, rail and energy industries. The intention is to introduce a SAR for health providers. Defra conducted an impact assessment on the introduction of a SAR in the water industry.⁶⁷ They found that there was no impact on equality issues. Whilst the water industry is very different from healthcare, it is important to note that safeguarding the security of essential services in the utilities industry has not impacted on equality. This is a potential result of introducing the economic regulator in health care.
- B79. However, in the health economy, the SAR will have further implications for providers. The improvements in the system come through making the playing field fairer by reducing barriers to entry caused by favourable treatment of NHS providers in times of insolvency. The SAR contributes to the overall gains in quality of healthcare caused by the introduction of the entire independent regulatory regime.
- B80. The impact on equality issues differs from the water industry, as quality of water is far less differentiable (e.g. it is either drinkable or not) than healthcare services (an entire range of service quality). Thus, increases in competition in the health economy are likely to have more effect on equality in the health care industry than the water industry. The SAR acts as a safeguard by ensuring the continuation of essential services, particularly vulnerable groups of patients (e.g. those in a remote location or unable to travel) are likely to be positively affected.

Staff

- B81. The new system with effective economic regulation may lead to increased entry and exit within services. Where services cease to be provided, or are delivered by alternative providers, there is a possibility that a disproportionate number of employees with the protected characteristics will be made unemployed, or struggle to find re-employment. However, there are legal safeguards against this. Employers cannot discriminate against staff with the protected characteristics when hiring, retaining or making staff redundant.
- B82. Consultation responses have highlighted the potential risk that increasing competition and pressures to achieve efficiency gains could lead to staff reductions, with an impact on the quality of treatment. There is a possibility that if this were to occur, it might have a disproportionate impact on patients who require the most resource intensive care (e.g. disabled or older patients). This is mitigated by the requirement for a provider to hold a CQC licence based on the quality of care. This should ensure that changes in staffing arrangements will not adversely affect the quality of service that patients receive.

Foundation Trusts

General

- B83. Statutory changes are expected to make an impact in two ways: first, through the repeal of the NHS trust legislation with NHS trusts being required to achieve FT status, and secondly through the liberalisation of FTs. On both counts, NHS statutory provider bodies will become closer and more accountable to their local populations (who are able to become members of FTs). Like other providers, they will also need to be responsive to GP commissioner contracts, including

⁶⁷ <http://www.defra.gov.uk/environment/flooding/documents/policy/fwmb/fwmiaregime-waterind.pdf>

through the widening of patient choice. All this has potential to make FTs more responsive to the diverse needs of their local communities.

- B84. Whilst concerns were raised by some consultation respondents that freeing providers might increase inequality by postcode lottery, it is important to note that variation of service in itself is not a weakness as long as providers are free to tailor services to meet the diverse needs of their local population.
- B85. The liberalisation of FTs must be viewed in the context of the wider reform of the NHS and many of the concerns raised in consultation are addressed by other policy proposals. For example, in addition to steps to strengthen FT governance there will also be strengthened mechanisms for patient voice, to raise and address matters of concern through the establishment of HealthWatch. HealthWatch will be a strengthened consumer voice that can promote patient and public involvement, and seek views on local health and social care services that can be fed back into local commissioning.
- B86. Furthermore, continued quality regulation and a transparent information strategy combined with a focus on quality and outcomes will ensure that any poor or unequal provision will be more easily identified and addressed than is currently the case. This will help address the perceived risks from consultation responses that increased freedoms lead to patients perceived as lower value getting marginalised.

Repealing NHS Trust legislation

- B87. The current position (a combination of FTs and non-FTs) is one where, depending on where you live, your local NHS provider may or may not be an FT. Progressing all NHS Trusts to FT status provides a key opportunity to ensure that all NHS healthcare is delivered by autonomous providers within a regulated market.
- B88. A key challenge to delivering the FT pipeline will be to ensure that the NHS Trusts preparing themselves for this status ensure that in this transition they continue to meet their responsibilities to advance equality.
- B89. Furthermore, and as a result of the consultation, Monitor will be given transitional intervention powers for new FTs for two years after their authorisations. This can help to ensure that newly authorised FTs do not fail unnecessarily (thus decreasing competition, particularly in rural areas).

Private Income

- B90. Removing the cap on the amount of private income that Foundation Trusts can generate will eliminate the arbitrary variations in the extent to which Foundation Trusts can raise private income.
- B91. As noted in paragraph 48, some of those who responded to the consultation were concerned that private patients could be prioritised over NHS patients, with the potential for waiting times for NHS patients to increase. However, there are a number of safeguards currently in the system that mitigate this risk including that:
- FTs will still maintain their principal purpose to provide goods and services for the purposes of the health service in England

- The NHS Constitution has enshrined an 18 week waiting time from referral to treatment as a patient right. NHS commissioners will therefore need to give due regard to whether they are commissioning care from providers that can honour this commitment.
- Each FT's governors act as community guardians and have a role in relation to the FT's significant investment and policy decision-making. (The Bill aims to strengthen their role further.)
- CQC will provide a quality threshold beneath which a provider cannot dip.

B92. FTs will also continue to be required to produce separate accounts for their NHS and private services. This can help ensure transparency and thus make sure that groups of every socio-economic status can access a good quality of care, free at the point of use.

Finance

B93. As noted above, some consultation responses feared that removing statutory borrowing limits might lead FTs to borrow too much and then to cut services to balance the books, with patients with complex needs possibly being disproportionately affected. However, removing the statutory control does not mean that borrowing will be uncontrolled. FTs will have their business plans appraised by the FT's directors with due diligence undertaken by lenders, and conditions on all debt (new DH loans, the historic taxpayer investment, or commercial debt) will constrain borrowing beyond levels that would present an unacceptable risk to the existing lenders – including the taxpayer.

B94. Another risk highlighted by the consultation was that for some areas of specialised healthcare there is a need for specialist facilities or equipment and there can be significant barriers to securing capital to provide them which could lead to those with complex needs being disadvantaged (as they can be less profitable services). Specialised healthcare will be picked up through NHS CB specialist commissioning which would ensure the right financial incentives to provide the services. It does however indicate that choice and competition could work less well for people who can only access their care from one or a few providers.

Merging, Acquiring and Separations

B95. Under the new proposed system, FTs will have greater autonomy in merging with or acquiring another FT or separating into two or more FTs, subject to the same controls that apply to other organisations (from creditors, economic regulation and competition authorities). This has the potential to enable FTs to organise themselves to better meet the needs of their local population.

Governance

B96. As a result of points made in responses to the consultation, we have made proposals to strengthen FT governance. These include a proposed new statutory duty on the governors to represent the interests of the members as a whole and of the public. This helps respond to the concern raised in consultation that the needs of patients accessing specialised services who travel from a much wider catchment area need to be protected as well as those of local patients. The Bill also provides powers for Monitor to host an independent panel which will be able to advise on concerns raised by governors about whether an FT is complying with its constitution or the underlying legislation.

- B97. As noted above, a few stakeholders were concerned that the new freedom for FTs to change their constitutions without an external check might create a risk that an FT would deny care to lesbian, gay, bisexual and transgender patients or employment to certain staff. As explained above, equality legislation will continue to apply to FTs and other providers, and no change that an FT makes to its constitution can override that. Measures to increase transparency and accountability (such as annual meetings of the membership at which the FT's annual report and accounts will be considered), to strengthen the role of governors (e.g. in relation to changes to the FT's constitution) and to clarify the roles and duties of governors and directors should ensure that an FT remains responsive to the needs and diversity of those it serves. In addition, all providers of NHS services must have regard to the NHS Constitution, which states that the NHS must provide a comprehensive service, available to all, irrespective of gender, race, disability, age, sexual orientation, religion or belief.
- B98. The Bill also makes clear that an FT may ask one or more of its partner organisations to appoint one or more of its governors. This can increase diversity and awareness by involving more key stakeholders, including those from specialist organisations. In addition to the measures in the Bill, including a responsibility on FTs to support their governors in fulfilling their role, DH is considering with the FT Network and FT Governors Association how training and support for governors can be strengthened, to help them discharge their responsibilities effectively.

Overall Assessment of Impact

- B99. We expect the economic regulation and FT liberalisation policies to have a positive and potentially significant impact on the advancement of equality for people with different protected characteristics. The new arrangements aim to improve services, and in particular their responsiveness to patient needs, by ensuring that all providers are able to compete on fairer terms. The overall effect will depend upon how the policies work as enablers of other White Paper policy commitments.
- B100. Expanding and improving the scope of the pricing function in Monitor could have a significant positive impact on equality over the longer term. Developing price regulation, strengthening the building blocks of tariff setting, increasing the scope and flexibility of national tariff and increasing the accuracy of price setting should all contribute to this.
- B101. The liberalisation of FTs and the introduction of the whole system of regulation should create conditions so that the benefits of competition among healthcare providers are accessible to more patients. The regulatory framework should enable any willing provider and choice policy to increase the quality of care received by all patients, and thus under increased market conditions providers will be incentivised to provide care tailored to their diverse populations and become dynamic and flexible enough to respond to commissioners' varied needs. To ensure continuity of service, the assets around designated services subject to additional regulation will be protected, whilst the Bill provides for a process in which local commissioners, providers and members of the public take control of the decision about which services to designate as subject to additional regulation.
- B102. However, we do not have enough evidence to make these assessments with as much confidence as we would like. Even if the necessary data sets were available, it would be difficult to attribute changes in equality made to specific areas of this policy. However, through policy development and consultation we have set out to mitigate all identifiable risks that may be created by this area of the Bill.

B103. Issues of particular relevance to socio-economic disadvantage have been considered in paragraphs B12, B22-B23, B48, B65 and B92 above. As noted there, the evidence on impact is mixed, so it is difficult to come to a firm view on the potential impact.

Recommended Actions

Involvement and Consultation

B104. We will continue to ensure that equality issues raised in the responses to consultation are used to inform ongoing development of the policy. We will ensure that the introduction of Monitor as economic regulator and the policy on NHS providers complies fully with equality legislation.

Transition to the new policy

B105. Until the new policy is finalised and implemented, the regulatory functions outlined in the consultation document and this assessment will continue to be undertaken by the organisations currently responsible. This will safeguard the continuity of services to patients during the transition period.

Joint Licensing Regime

B106. Monitor will be required to have due regard to the need to advance equality as part of its responsibilities as a public body. Currently, NHS contracts between providers and commissioners explicitly recognise the obligation of providers to provide services to all. The obligation may:

- Remain within the contract between providers and commissioners.
- Remain in the contract and be included in the licensing agreement.
- Be removed from the contract and rely on legislation.

B107. The question remains whether Monitor should have special powers to revoke or cancel a licence if equality standards in provision are not met. Paragraph 16 explains how the CQC has responsibility for ensuring that equality issues are upheld by providers, so it may be the case that Monitor will not need to duplicate these powers, though, as a public body it does have a responsibility to pass on information pertinent to another regulator's functions. The option will be chosen on the basis that it best promotes equality within the system.

B108. An improved method of data collection via licensing commitments, alongside current data collections, may provide evidence in the future to assess equality impacts. As part of the licence agreement (with CQC and/or Monitor), providers could be required to record participation information (e.g. % of healthcare used, by whom) by the protected characteristics covered by the public sector equality duty, in order to reveal any issues around inequitable access to services and outcomes. If equality of access is not being achieved, providers could be required to take action to address any inequalities.

Pricing Regulation

B109. It is within Monitor's remit to devise a pricing methodology, to be agreed through a public consultation process, engaging with both the NHS Commissioning Board and providers. It is possible that Monitor could set prices that recognise the different costs associated with patients

from more deprived areas. This would work alongside the recognition of deprivation in the funding formula to GPs and Consortia, to compensate providers who operate in more deprived areas for providing a better service to patients in these areas. This would only be a mitigating factor if the different costs associated with patients in deprived areas was included as part of Monitor's methodology.

Monitor to be Subject to Review by the Competition Commission

B110. The Competition Commission will conduct a review every seven years of competition and regulation in public healthcare services. It will be responsible for considering whether the healthcare market is functioning effectively in delivering services to patients, including those with protected characteristics. Whilst the Commission currently will not have a specific equality remit, vulnerable groups may be considered in some instances. In some other regulated sectors, regulators have imposed conditions to ensure that more vulnerable customers are protected, for example, limiting charges payable by customers with pre-pay electricity meters (who tend to be low-income households), despite the higher billing costs of such arrangements. If equality is considered in a particular review, it will help to improve the availability of evidence in this area in the future as well as providing insights into the potential improvements that can be made to the regulatory regime.

Liberalising FTs: Governance

B111. We are discussing with stakeholders how FT governance can be strengthened through explicit training and support, particularly during the transition, including how governors can best help the organisation discharge its equality and diversity duties. This is the case both for the governors of existing FTs and for the new governors that will be needed in NHS Trusts that achieve FT status.

General

B112. Given that we were unable to find any specific evidence relating to religion or belief, pregnancy and maternity, or sexual orientation, it is important that the Department, the Commissioning Board and the others involved keep under review what actions can be taken in order to increase the evidence base in the future.

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Table 1: Impacts on Patients with Protected Characteristics

The first table below considers, for each of the protected characteristics to which the public sector duty in the Equality Act 2010 applies, the potential impact of the proposals on economic regulation and FT liberalisation and opportunities for promotion/mitigation.

The second table presents some of the issues covered by the first table in a different form, by summarising the potential impact and mitigation/opportunities for promotion in relation to the specific proposals on FTs. This table does not include a characteristic-by-characteristic analysis, because that is already provided by the first table.

Table 1: Potential Impacts on Protected Groups

Protected Characteristic	Potential Impacts Identified	Mitigation /Opportunities for Promotion
Race	<p>There is a potential risk that more socially deprived areas will not attract the same level of competition as more affluent areas. Evidence suggests that a high proportion of BME patients live in socially deprived urban areas, so could potentially not receive the benefits of competition.</p> <p>Evidence shows that a disproportionate number of mental health sufferers come from the black and minority ethnic (BME) population. There is a risk that the current tariff does not cover mental health services, which could lead to the budget for these services being reduced.</p> <p>Certain smaller ethnic groups, such as gypsies and travellers experience stark inequalities. It may be difficult to source robust health intelligence about these communities, leading to inadequate needs assessment and inequities in service provision</p>	<p>Commissioners would be responsible for mitigating the potential risk that particular groups receive an unequal quality of service. Monitor will have a specific duty to promote competition. This will relate to all areas of the country. This will mitigate this risk and provide an opportunity to promote the benefits of competition in more socially deprived areas.</p> <p>1Pricing regulation is likely to expand significantly in scope including some mental health services. This will help to safeguard healthcare spending for these individuals.</p> <p>Existing national research and intelligence on ethnic communities can be collated and made widely available to healthcare professionals, e.g. primary care service framework for Gypsies & Travellers⁶⁸. Local Joint Strategic Needs Assessments can be used to capture intelligence on seldom heard groups that is currently held by local</p>

⁶⁸ http://www.pcc.nhs.uk/uploads/primary_care_service_frameworks/2009/ehrg_gypsies_and_travellers_pcsf_190509.pdf

		authorities and voluntary organisations
Disability (including carers of disabled people)	<p>Disabled patients may not have the capacity to travel and choose a hospital further away from their home. More mobile patients will be able to travel and choose a better hospital if they are not happy with the care at their local provider. This creates an inequality as some patients can access better care because they can travel further. It may also create a monopoly provider over the patients who do not have the capacity to travel, giving this provider less incentive to improve the quality of care.</p> <p>The accuracy of the building blocks of the price setting function has implications for patients with complications and comorbidities. If the price is set more accurately to reflect the cost of treating these patients, it improves the incentives for providers to increase their service offer.</p> <p>People with learning disabilities (PWLD) may not be sufficiently informed of the changes to the health and care system, resulting in poorer access to primary care services and increased attendance at A&E</p>	<p>Commissioners would be responsible for mitigating the potential risk that particular groups receive an unequal quality of service. Competition between providers for some patients should improve the quality of care in all providers, even if not all patients are equally likely to travel. This will mitigate the risk of less mobile patients receiving a lower quality of care to those that may be able to travel further for treatment.</p> <p>The NHS Information Centre (IC) is currently reviewing the complications and comorbidities splits for each chapter in HRG4, which are based on a set of principles such as “minor degree has lower rank than severe degree”, but also takes into consideration the effect of comorbidities on length of stay. This should have a positive impact on disabled patients once the cost of treating comorbidities is more accurately reflected in the building blocks of price setting. Monitor will be expected to set prices that adequately reflect the cost of service delivery.</p> <p>More diverse providers may allow specialisation with some focussing on addressing particular needs, such as for PWLD. Providers can work with Local Healthwatch, advocacy services and tailored local learning disability advocacy groups to build the capacity of PWLD to understand the changes and engage with health services</p>
Gender Reassignment	There is a potential risk that rural areas will not attract the same level of competition as urban areas. Evidence suggests that a higher proportion of transgender patients live in rural areas, so could potentially not	Commissioners would be responsible for mitigating the potential risk that particular groups receive an unequal quality of service. Monitor will have a duty to promote competition in all areas. This will mitigate the risk and provide an opportunity to promote the benefits

	receive the benefits of competition.	of competition in rural areas. The threat of choice and competition can increase the quality of care, even if it is not fully exercised in an area.
	Lack of data on trans service users could lead to inadequate needs assessment and inequities in service provision	The Department of Health Equality and Inclusion Team will be working with the Equality and Human Rights Commission (EHRC) to help strengthen the evidence base on the health needs of trans people
Age	As for disabled patients, less mobile older patients could find it difficult to travel and choose providers that better meet their needs. This creates an inequality as some patients can access better care because they can travel further. It may also create a monopoly provider over the patients who do not have the capacity to travel, giving this provider less incentive to improve the quality of care.	Commissioners would be responsible for mitigating the potential risk that particular groups receive an unequal quality of service. The threat of choice and competition can increase the quality of care, even if it is not fully exercised by particular groups. There is some evidence that older people are prepared to travel, sometimes more than younger people, to access the services and clinicians they wish to see. Monitor will have a duty to promote competition where appropriate to achieve the best possible outcomes for patients of all ages.
	As for disabled patients, the price setting function has implications for older patients, which suffer from complications and comorbidities.	Improving how complications, comorbidities and length of stay are included in the price setting process should have a positive impact on older patients, once the cost of treating complications and comorbidities is more accurately reflected in the building blocks of price setting. This occurs as providers are more adequately compensated for the costs of delivering care and therefore may expand their service or improve quality for older patients.
Sexual Orientation	The promotion of competition and fairer playing field may provide an opportunity to improve equality in this group.	Commissioners would be responsible for mitigating the potential risk that groups such as this receive an unequal quality of service. The enhanced opportunity for providers of niche services to deliver NHS services (through better access to tendering for services, any willing provider expansion and/or the fairer playing field) may allow services tailored for gay, lesbian or bi-sexual patients to expand and improve the quality of care for this cohort.

	<p>Older lesbians, gay men and bisexual people may be reluctant to approach health services as in the past, health professionals were those attempting to 'cure' their sexual orientation</p> <p>Lack of data on LGB service users could lead to inadequate needs assessment and inequities in service provision</p>	<p>Providers can work with Local Healthwatch and local advocacy groups to build trust among older LGB communities and facilitate greater involvement. This may be easier for niche providers in a diverse market.</p> <p>Existing national research and intelligence on these communities can be collated and made widely available to healthcare professionals.</p> <p>Local Joint Strategic Needs Assessments can be used to capture local intelligence on seldom heard groups currently held by local authorities and voluntary organisations</p> <p>The NHS Commissioning Outcomes Framework will ensure that, where possible, outcomes are measured by equality characteristics so inequities between different groups can be identified and addressed.</p>
<p>Religion or Belief</p>	<p>The promotion of competition and fairer playing field may provide an opportunity to improve equality in this group.</p> <p>GP consortia may lack specific knowledge of how to commission culturally appropriate care for particular religious groups</p>	<p>Commissioners would be responsible for mitigating the potential risk that this group receives an unequal quality of service. The enhanced opportunity for providers of niche services to deliver NHS services (through better access to tendering for services, any willing provider expansion and/or the fairer playing field) may allow services tailored for patients of certain religion, belief or socio-economic status to expand and improve the quality of care for this cohort.</p> <p>Existing guidance can be collated and easily available to GPs to inform their commissioning practice</p> <p>Engaging with religious communities and denominations (e.g. Muslims, Hindus) can provide an effective way of targeting health messages or preventive services to certain ethnic groups</p> <p>NHS Commissioning Board's commissioning guidance can cover commissioning of these services. The Board, when issuing such guidance, will have a statutory duty to have regard to the need to reduce inequalities between patients with respect to their ability to</p>

		access health services and the health outcomes achieved. The NHS Commissioning Outcomes Framework will ensure that, where possible, outcomes are measured by equality characteristics so inequities between different groups can be identified and addressed
Sex	The promotion of competition and fairer playing field may provide an opportunity to improve equality in this group.	Commissioners would be responsible for mitigating the potential risk that people of either sex receive an unequal quality of service. The enhanced opportunity for providers of niche services to deliver NHS services (through better access to tendering for services, any willing provider expansion and/or the fairer playing field) may allow services tailored for men and women to expand and improve the quality of care for this cohort.
Pregnancy and maternity	The promotion of competition and fairer playing field may provide an opportunity to improve equality in this group.	Commissioners would be responsible for mitigating the potential risk that this group receives an unequal quality of service. The enhanced opportunity for providers of niche services to deliver NHS services (through better access to tendering for services, any willing provider expansion and/or the fairer playing field) may allow services tailored for pregnancy and maternity to expand and improve the quality of care for this cohort.

Table 2: FT specific proposals

Potential impacts identified	Mitigation/opportunities for promotion
Progressing NHS Trusts to FT status could involve changes to services, which might mean people with protected characteristics receive a poorer service.	Populations that are currently served by NHS Trusts will have the opportunity to become members and governors as those Trusts become FTs: this can help make those providers more accountable to local needs. Monitor will have transitional intervention powers in relation to new FTs, which will help to ensure that new FTs do not fail unnecessarily.
FT governors and (active) memberships	It will continue to be possible for FTs to opt to have a patient and carer constituency, as well as a public

<p>may not be fully representative of the communities they serve, including patients and service users from outside the area covered by the FT's public constituency. This could mean that the FTs concerned provide a poorer service for people with protected characteristics.</p>	<p>constituency, in their membership, and for FTs to invite partner organisations (which could include voluntary organisations) to appoint governors.</p> <p>The duties of governors will be clarified. In particular, the Government proposes that legislation should make clear that it is the duty of the governors to represent the interests of the members as a whole and of the public. FTs will have a particular responsibility to have regard to the need for those eligible for membership to be representative of those served by the FT in defining constituencies for membership.</p> <p>FTs will have a new responsibility to support governors in their role.</p> <p>In addition, FTs, like other providers, will compete to provide services and will be subject to quality licensing by CQC. This is expected to maintain and increase their sensitivity to the needs of different patients.</p>
<p>Removal of the private patient cap might result in lower priority for NHS patients.</p>	<p>It will remain the principal purpose of each FT to provide goods and services for the purposes of the health service in England. FTs will continue to be required to produce separate accounts for their NHS and private services. Commissioners will continue to have regard to the NHS Constitution in commissioning services.</p>
<p>Loss of local services might result from</p> <p>a) removal of the statutory borrowing limits, if that increases the risk of FT failure, and/or b) new arrangements for FT mergers, separations and acquisitions</p>	<p>Services designated for additional regulation will be protected, whether they are provided by FTs or by others.</p> <p>Removing statutory borrowing limits will not mean that FT borrowing is uncontrolled: conditions on all debt will constrain borrowing beyond levels that would present an unacceptable risk to lenders.</p> <p>FT mergers and acquisitions will be subject to the same controls as apply to other providers (by creditors, and in relation to designated services and to competition). They should not be seen in terms only of a threat to local services: they may also result in improved services that are more sustainable and/or more responsive to patient needs.</p>

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Equality Impact Assessment

Annex C: Liberating the NHS – Local Democratic Legitimacy

Introduction

- C1. The aim of this policy is to increase democratic accountability in health, through the setting up of local health and wellbeing boards. These will give many opportunities to make a positive impact on equality by providing an opportunity for members of the public including service users of all groups and communities to take part in shaping local services to meet the needs of the local population in all its diversity.
- C2. To enhance their role in health, the Government originally proposed that local authorities be given the following functions:
- To assess the needs of the local population and lead the statutory joint strategic needs assessment;
 - To promote integrated working and partnership across areas, including through promoting joined up commissioning plans across the NHS, social care and public health;
 - To support joint commissioning and pooled budget arrangements, where all parties agree this makes sense; and
 - To undertake a scrutiny role in relation to major service redesign.
- C3. Through elected councillors, local authorities will bring greater local democratic legitimacy to these roles. They will bring the local perspective into commissioning plans and promote integrated working of local services across the boundaries between the NHS, social care and public health.
- C4. The initial consultation⁶⁹ *Increasing local democratic legitimacy in health* asked for views on whether this role should be given directly to Local Authorities, who would then create the necessary structures to deliver them, or to a prescribed form called the health and wellbeing board. Respondents have been strongly supportive of the proposal to have statutory health and wellbeing boards in each local authority, with requirements of participation, and a minimal, clearly established set of high level functions.
- C5. The consultation response therefore proposes the creation of minimal statutory health and wellbeing boards, which would bring health, public health and social care commissioners together with elected representatives and local HealthWatch representing patients and the public. The intention is to provide a framework to promote integrated working and partnership working between the NHS, social care, public health and other local services and improve democratic accountability. The local authority will bring partners together to agree priorities for the benefit of patients and taxpayers, informed by local people and neighbourhood needs.
- C6. The proposals are discussed in more detail in the Government's response to the White Paper consultations⁷⁰.
- C7. The aims of local health and wellbeing boards are consistent with the fairness, freedom and responsibility agenda:
- Putting patients and the public first, improving public voice;

⁶⁹ See http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH_117586

⁷⁰ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122661

- Providing incentives to respond to patient wishes, improving coordination and integrated working between services and moving towards a patient-led NHS.

C8. The intention is that these functions for Local Authorities, building on existing structures and processes, will be performed with greater efficiency and lead to improved outcomes for the local areas they serve. The next paragraphs discuss their impact on equality groups.

Relevance to Equality and Diversity

C9. This policy is expected to strengthen local participation in reviewing and shaping health services and local accountability for their delivery against local needs, and as such should have a positive impact in improving services and outcomes for people whose differential needs are not well met currently.

C10. The purpose of this equality impact assessment (EIA) is to inform development of this policy so that, as far as possible, it:

- (iii) Eliminates discrimination and does not generate or exacerbate inequalities in access to healthcare or health outcomes for patients and the public or employment and progression opportunities for actual/potential employees;
- (iv) Supports local efforts to reduce inequalities, promote equality and foster good relations between people from protected groups and those who are not.

C11. In carrying out this assessment, we have considered the following dimensions:

- Age
- Disability
- Gender reassignment
- Pregnancy and maternity
- Race or ethnicity
- Religion or belief
- Sex
- Sexual orientation
- Socio-economic status

C12. We have chosen to include all the relevant protected characteristics covered by the Equality Act in accordance with good practice guidance from the Equalities and Human Rights Commission (EHRC). Not all the provisions of the Equality Act are yet in force; some, such as the prohibition on age discrimination in services and public functions are still under consideration, and the public sector equality duty is due to commence in April 2011. Our consideration of these characteristics takes into account that we expect these measures to be in force when these provisions come into effect.

C13. Socio-economic status is not one of the protected characteristics that must be covered in the public sector equality duty and therefore in the EIA, but has been included for completeness of impact on current health inequalities.

The Equality Act 2010 and Powers of the Secretary of State

C14. The Equality Act aims to simplify, harmonise and strengthen equality law, replacing nine major pieces of legislation and around 100 other instruments with a single Act. It received Royal

Assent on 8 April 2010. The main provisions in the Act came into force in October 2010 and the single public sector equality duty will come into force in April 2011⁷¹.

- C15. The single public sector equality duty covers race, disability, and gender (existing duties), plus age, sexual orientation, religion or belief, pregnancy and maternity, and gender reassignment. These dimensions are collectively referred to as the protected characteristics. All public bodies, including those changed or set up through these provisions, must have due regard to the need to:
- eliminate unlawful discrimination, harassment, and victimisation;
 - advance equality of opportunity; and
 - foster good relations between those who share a relevant protected characteristic and those who do not.
- C16. This general duty is underpinned by specific duties, to help public bodies meet the general duty. The Government has recently undertaken a public consultation on the specific duties.
- C17. The Equality Act 2010 will ensure that all public bodies within the health service, including the NHS and the public health service, are obliged to comply with principles of equality. This will include those bodies established under the Bill, such as GP consortia, and those whose functions are changed, such as some of the arm's-length bodies (CQC, NICE and Monitor). These duties also apply to private providers in so far as they are providing NHS services, on the basis that the provision of services for the purposes of the health service is a function of a public nature. This can be brought about by measures such as the inclusion of contractual terms relating to equality in contracts with such organisations, where this is considered necessary.
- C18. The Government's current consultation document on the specific duties proposes that statutory organisations set out the equality outcomes they aim to achieve, including specific and measurable objectives outlining how they plan to achieve them.⁷² It is intended that this approach will be in line with the cross government agenda of transparency and democratic accountability; patients and the public should be able to see progress against their stated objectives and judge whether GP consortia or the NHS Commissioning Board are working toward the right equality outcomes.

Summary of Evidence

- C19. This EIA relies on evidence and stakeholder feedback to:
- provide supporting evidence where actual or potential impacts on equality and human rights were identified
 - assist with developing proposals for mitigating potential negative impacts
 - demonstrate how proposed reforms can promote equality and human rights, where possible
- C20. Table 1 summarises the evidence on access to health services and health outcomes by protected characteristic. This section outlines the available evidence on the impact of local democratic legitimacy on equality.

⁷¹ From April 2012, the ban on age discrimination in provision of goods, facilities, services and public functions will be implemented.

⁷² Government Equalities Office (2010) Equality Act 2010: The public sector Equality Duty. Promoting equality through transparency - A consultation. London: Government Equalities Office

- C21. These proposals provide local authorities with the opportunity to strengthen and improve the current JSNA process, promote integration across health and social care, and improve coordination between the different players within the local health and social care landscape. These improvements are made possible by the following key themes of the proposals: increasing local democracy; the engagement of the relevant stakeholders; and placing the health and wellbeing boards at local authority level.
- C22. In order to promote local democratic legitimacy, a minimum of at least one elected representative will be required to sit on the health and wellbeing board to represent the views of the people of the area. This will be either councillors nominated by the Mayor or executive leader of the council, and/or the mayor or leader of the council. This should provide a more democratic dimension to the board's discussions, providing a route for elected representatives to influence commissioning decisions on behalf of their constituents.
- C23. The principal lever for the health and wellbeing board to influence commissioning decisions will be through the development of the JSNA and the joint health and wellbeing strategy (JHWS), which will examine the present and future needs of an area across health and social care and provide a strategy for meeting those needs. Elected representatives, and the representative from HealthWatch, will be expected to contribute their views. An improved needs assessment will increase the opportunity for improved outcomes for local constituents as services can be designed in a way that better meets their needs. As mentioned in the Impact Assessment above, the proposals for health and wellbeing boards are supported by the NHS information revolution⁷³. Improved information to support choice and accountability will create greater transparency for patients and more information available that is valid and based around genuine outcome measures⁷⁴. A JSNA and joint health and wellbeing strategy that is based on information of a higher quality will, all things being equal, to an improved needs assessment and then strategy and actions resulting from it, ultimately creating the potential for better catering of patient needs and improved outcomes for patients.
- C24. We are aware that several groups with protected characteristics are underrepresented as councillors. The National Census of Local Authority Councillors for 2008 shows 68.4% of councillors were male, with only 30.8% female. 3.4% came from an ethnic minority background compared with the percentage of BME people in the general population (9.5%). The average age of councillors had increased from 55.4 years in 1997 to 58.8 years in 2008. The proportion under 45 fell from 18.4% to 13.1% over the same period.⁷⁵ However, ensuring the election of a more representative set of local councillors is beyond the scope of this bill. When developing both the JSNA and the JHWS, we would expect both local councillors and local HealthWatch to represent the needs and interests of all their constituents. More detail on how HealthWatch will ensure it is representative is contained in the relevant section of the impact assessment.
- C25. Currently, JSNA describes a process that identifies current and future health and wellbeing needs of a population in light of existing services, and informs future service planning taking into account evidence of effectiveness, and identifies the 'big picture'⁷⁶. It includes provisions that the needs of the whole population be assessed, including those from different equality groups. An originally stated means of performing a JSNA was community engagement, "actively engaging with communities, patients, services users, carers, and providers including the third

⁷³ See: *Equity & Excellence: Liberating the NHS*, page 13, and 'An information revolution: A consultation on proposals' http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_120080

⁷⁴ These outcome measures for the information revolution will be further underpinned by the NHS Outcomes Framework, the outcomes that the NHS is held to account by. See: 'Transparency in outcomes: A framework for the NHS', http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH_117583

⁷⁵ *Communities and Local Government Duty to Promote Democracy Equality Impact Assessment*, August 2009

⁷⁶ 'Guidance on Joint Strategic Needs Assessment', DH, 2007.
http://www.dhcarenetworks.org.uk/library/Guidance_on_JSNA.pdf

and private sector providers to develop a full understanding of needs, with particular focus on the views of vulnerable groups.”⁷⁷

C26. This view suggests that JSNAs could serve an important function in identifying where services need to act to eliminate unlawful discrimination or promote equality. The 2007 Equalities Review⁷⁸ placed an aspirational view on equality that “an equal society protects and promotes equal, real freedom and opportunity to live in the way people value and would choose, so that everyone can flourish. An equal society recognises people’s different needs, situations and goals, and removes the barriers that limit what people can do and be.” As highlighted by *Race for Life*, when applied to health and wellbeing, this perspective encourages an approach based on responsiveness. Where bodies are understanding, being respectful of and relevant to the health beliefs, practices, culture and needs of diverse individuals and populations. Moving responsibility for JSNAs to Health and Wellbeing Boards, creates an increased opportunity for this responsiveness to be manifested and the JSNA process to be improved in relation to protected equality characteristics.

C27. The following diagram summarises the four basic dimensions of JSNAs, taken from *Race for Health*⁷⁹:



Figure 2: Dimensions of JSNA

C28. By moving the responsibility to health and wellbeing boards in local authorities and underpinning it through local democratic accountability and the membership and make-up of the boards will impact on the fourth dimension in the above diagram. In particular, community involvement and engagement is supported and has the opportunity to be improved. Improved community engagement can make the needs assessment more representative which in turn creates the opportunity to improve how the needs of the community are catered for.

C29. The national Children and Adolescent Mental Health Services CAMHS review suggested that the JSNA be improved, commenting that they “believe that all stakeholders should contribute to a comprehensive, multi-agency assessment of local need that is used.”⁸⁰ Undertaking the JSNA in the context of local democratic involvement is a step towards this.

C30. A recent report by *Race for Health* produced certain recommendations for the improvement of JSNAs with respect to race equality issues. In particular, the report found that in every dimension in the diagram above, developing more culturally responsive JSNAs involved working

⁷⁷ *ibid*, page 8.

⁷⁸ Cabinet Office (2007), ‘Fairness and Freedom: The Final Report of the Equalities Review’. (<http://archive.cabinetoffice.gov.uk/equalitiesreview/>)

⁷⁹ ‘Towards Culturally Responsive JSNAs: a review of race equality and JSNA practice’, *Race for Health*, August 2010

⁸⁰ ‘Children and young people in mind: the final report of the National CAMHS Review’ November 2008

with communities and stakeholders, aligning strategies⁸¹. Full involvement and engagement of the community and stakeholders was highlighted as a further recommendation to improve the analysis of the needs of ethnic groups. As the report noted, transition to the new NHS arrangements could provide the opportunity to consider the key messages and actions for improvement identified in the report. There was particular reference to the proposals for local authorities increasing their responsibility in population health and that this will provide a positive impact. There will be a greater opportunity for the proposals to improve current local authority culture and processes around race equality and for the proposals to supplement the insights from this report.

- C31. The impact assessment and equality impact assessment for the 'Commissioning framework for health and wellbeing' that initially introduced the JSNA process underlined the positive impact on equality the process had⁸². In particular, the assessment notes that there is a high probability that the proposal will not have an adverse affect and correspondingly that the proposal is "highly likely to promote equality of opportunity and good relations" with a high potential where the JSNA is carried out robustly, with full engagement with all groups within the local population. Where this does not happen there may be a negative impact on any groups including those with protected characteristics whose needs are not adequately assessed. The change to a new strengthened system with health and wellbeing boards should increase the effectiveness of JSNAs by increasing opportunities for wider engagement in the JSNA process by people who have been hard to engage on the past. The initial equality impact assessment considered the impact of the JSNA on the individual equality groups. This equality impact assessment builds upon the points made in the initial equality impact assessment and, as argued, does not create any negative impact on the individual equality groups. As the initial assessment mentioned, "it may be right to consider [equalities issues] in the round, at the same time as keeping the individual in mind. (page 27). The proposals for health and wellbeing boards will create the increased potential for this to happen.
- C32. The response to the consultation on the commissioning framework⁸³ also detailed that the views of respondents was supportive of the JSNA process and its impact on different groups. Specifically agreement was seen that "the approach on JSNAs would support the undertaking of a needs assessment of an individual, a group or a community." We are of the opinion therefore that strengthening the process by which JSNAs are performed and reinforced through the joint health and wellbeing strategy will therefore have no negative implications for protected equality characteristics, as this is a significant strengthening of existing attempts to identify areas of unmet need.

Summary of stakeholder feedback

Public Health Observatories support for local democracy in health

- C33. The Association of Public Health Observatories, and its constituent regional Public Health Observatories published various regional reviews of the JSNA process which included recommendations to improve the process⁸⁴. In particular, North West Public Health Observatory noted that JSNAs have been hindered by a lack of coordination or alignment between Local Authorities and NHS partners and that JSNA reports often provided little detail on how

⁸¹ 'Towards Culturally Responsive JSNAs: a review of race equality and JSNA practice', *Race for Health*, August 2010

⁸² See: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_072611.pdf

⁸³ See:

http://collections.europarchive.org/tna/20100509080731/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_081864.pdf

⁸⁴ See <http://www.apho.org.uk/resource/aphosearch.aspx>

partnerships are involving local communities. They recommended that a better coordination of local and regional planning between NHS and LA partners would contribute to the JSNA having a greater impact⁸⁵. The proposals for the statutory framework for Health and Wellbeing Boards aim to cater for these recommendations, creating the opportunity for improved JSNA processes for all equality groups.

C34. It is useful also to examine the recommendations of the Association of Public Health Observatories (and in particular of the North West Public Health Observatory). The recommendations and comments from local JSNA partnerships, with reference to equality, are answered for by the proposals for Health and Wellbeing Boards. In particular those performing JSNAs should:

- “draw in a wider collection of existing community research to ensure coverage of local issues.”
- “more clearly identify that they are developing broader inter-agency partnerships, so that there is: closer involvement of local communities; better links and integrated working with plans and programmes; and inclusion of the NHS and all directorates from local authorities (e.g. housing, transport, leisure and education/children services).”

C35. The inclusion of relevant local specialists on community issues, including health care (see below) and of local constituents of local authorities, through democratically elected councillors, in the health and wellbeing board creates the opportunity for these recommendation to be met and improved JSNAs to be realised.

C36. The examples above also stress the need for the relevant people to be engaged in the JSNA process. This not only includes patients, the public and constituents of local authorities but the relevant professionals from the local health and social care arena. As the response to the consultation outlined, the statutory framework of the Health and Wellbeing board makes provisions for a minimal membership of people who sit on the board. Ensuring these people – such as representatives from local GP consortia, local authority directors on health care, social care and children’s services, local HealthWatch and, in certain circumstances the NHS Commissioning Board – along with democratically elected representatives, sit on the board and inform and are engaged in the work of the board creates the opportunity for improved engagement. This improved engagement creates the potential for improved integrated working and partnership across areas and supporting joined up commissioning and pooled budget arrangements. This creates the potential for services to be better designed to meet the needs of constituents, including the diverse protected equality characteristics.

Joint working in health and local government to strengthen local democratic legitimacy

C37. By placing the health and wellbeing boards at Local Authority level there is the increased possibility of joint working across different areas. For example, local authorities currently have responsibilities regarding “general health determinants”⁸⁶, namely:

- standards of housing, transport services or public safety,
- employment prospects, earning capacity and any other matters that affect levels of prosperity,
- the degree of ease or difficulty with which persons have access to public services,

⁸⁵ ‘Joint Strategic Needs Assessment North West Regional Review’, *North West Public Health Observatory*, June 2009.

⁸⁶ Defined by section 309F(5) of the Greater London Authority Act 1999.

- the use, or level of use, of tobacco, alcohol or other substances, and any other matters of personal behaviour or lifestyle, that are or may be harmful to health; and
 - any other matters that are determinants of life expectancy or the state of health of persons generally.
- C38. There is therefore the opportunity for the health and wellbeing boards to work closely with colleagues in local authorities who work on the areas listed above to see the overall picture and take a holistic view of both local needs and local services, including both health, social care and public health. This increases the possibility of encouraging decisions that lead to improved outcomes for local constituents across the different protected equality characteristics.
- C39. This view is backed up by the National CAMHS review 2008 on children and young people who recommended that the JSNA be “used to look at the needs of children and young people holistically and objectively.” By placing responsibility for the JSNA at local authority level, the opportunity for this is increased.
- C40. ‘Tackling Health Inequalities’ (2003)⁸⁷ outlined what could be different from the status quo in terms of engaging communities and individuals. The report highlighted certain measures that would improve health inequalities, that the proposals for increasing local democratic legitimacy in health are compatible with. In particular:
- Local people being involved in identifying health needs, influencing decision making and evaluating their local services;
 - Developing new ways of engaging communities in the planning and provision of services, and promoting communities to stimulate greater community participation in decision making; and
 - Recognising and making best use of links between specific health policies and those that are initiated outside of the Department of Health but play a key role in social support, e.g. employment and education policies.
- C41. The policies of increasing local democratic legitimacy in health are consistent with the measures highlighted above. Specifically, by creating local health and wellbeing boards, local people, both sitting on the board, and having a say in who sits on the board (through democratic power), will be actively engaged the measures listed above. The creation of health and wellbeing boards therefore increases the opportunity of health inequalities being better catered for.
- C42. In their current legal context, public bodies have a duty to carry out all their functions with due regard to:
- Eliminating unlawful discrimination, harassment and victimisation;
 - Advancing equality of opportunity between people sharing a characteristic protected by equalities legislation (e.g. race, gender) and those who do not share it; and
 - Promoting good relations between persons who share a protected characteristic and those who do not share it.
- C43. As the description of the JSNA process outlines above, the JSNA is a tool to identify the needs of different groups within a local population. The current JSNA core dataset⁸⁸, that is revised and added to regularly, includes data on all the protected characteristics in relation to local populations. As this dataset is monitored for the JSNA process and coupled with the provision

⁸⁷ Dept. of Health (2003) *Tackling Health Inequalities: A Programme for Action*. Report Cm6374. Dept. of Health, London.

⁸⁸ See: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_099262.pdf

on Local Authorities to carry out their functions with regard to the equality provisions outlined above, it is asserted that the JSNA process with increased local democratic legitimacy will create no negative implications to protected characteristics. Where the strengthened JSNA is done effectively, we anticipate a positive impact, with services being reshaped to meet identified need. Where enhanced JSNAs do not work effectively, we do not anticipate a change from current practice, as local authorities already have a duty to identify the needs of their populations.

Discussion of potential impacts

- C44. We do not believe there are potentially negative impacts of imposing stronger democratic engagement and involvement in local decision making, as we have developed a structure which allows councillors and other relevant local representatives to engage and influence clinicians and commissioners.
- C45. The proposals outlined in the White Paper and the response to the consultation show the main theme of increasing local democratic legitimacy is shifting functions to Local Authorities. In particular, health and wellbeing boards will be created, using a minimal statutory framework, as a statutory body of the local authority. As a body of the local authority it will be duty bound under the equality duties already in place on the local authority, such as those highlighted above. This fact would therefore support the assessment in this equality impact assessment that no adverse impact on equality will be evidenced.
- C46. Given the minimal nature of the functions and powers transferred to democratically accountable local authorities and the make-up of health and wellbeing boards, the proposals create the opportunity to improve the JSNA process, engagement with relevant health professionals, and the potentials for working across many general health determinants.
- C47. As the statutory proposals are based on improving current processes and structures, that already aim to meet and cater for the needs of protected equality characteristics, we assess that the impact on equality groups is likely to be positive. In particular, for the reasons above, the Department is of the view that the policy will have a positive impact on equality and promote equality between people of the following characteristics:
- disabled and those that are not;
 - different genders;
 - those in marriages or civil partnerships and those who are not;
 - different races;
 - different religions or beliefs;
 - different age groups;
 - different sexual orientations.
- C48. Beyond the general anticipated impact on every member of the population, as discussed above, there is currently insufficient evidence to assess whether health and wellbeing boards will have a differential impact on different groups of people. They will play a crucial role in ensuring every needs assessment and commissioning priority best reflects the needs of local people. There may be some minor additional benefit to some groups, such as the elderly or disabled, who may benefit more from increased integration as they use services more frequently. However, this is dependent on a number of other factors outside the control of health and wellbeing boards, for example improved commissioning decisions made by individual local authorities and consortia.

C49. We anticipate that in most circumstances this will depend on local circumstances and structures. As committees of the local authority, health and wellbeing boards will also remain under the duties established in the Equality Act to promote equality and the interests of protected groups.

Recommended Actions

C50. The responses to the consultation on increasing local democratic legitimacy highlighted some concern for how communities and the voluntary sector would be supported on the proposals for health & wellbeing boards⁸⁹. These measures outlined below also link to measures to support the implementation of the White Paper and Health and Social Care Bill from other individual policy areas. Specific actions include the following:

- The Department of Health has commissioned the JSNA Development Programme in 2010/11 to refresh the 2007 DH JSNA guidance in light of Coalition policy. It will also work with Local Government Improvement and Delivery (LGID) and other partners to provide good practice support during the transition, including case studies & tools to assist with:
 - (i) preparations for transfer of JSNA to health and wellbeing boards;
 - (ii) wider statutory & community involvement;
 - (iii) using JSNA to informing commissioning; and
 - (iv) readying the JSNA contribution to scrutiny functions
- The Government is also establishing a group of early implementer councils to work through with NHS commissioners some key issues around implementation of the proposals. These will include how to use the health and wellbeing boards as a lever for greater integrated working through pooling and aligning budgets, how to work together with GPs over different geographies with a focus on local population needs and how health and wellbeing boards can work effectively with a wide range of services.
- There will be a comprehensive system of “shadow” health and wellbeing boards up and running across the country in 2012/13, prior to the formal assumption of powers and duties in April 2013. As committees of the local authority, each shadow health and wellbeing board will be under a duty to advance equality, in line with all public sector organisations.

⁸⁹ Further details can be found in the Government’s response to the consultation, *ibid*.

Table 1: Potential Impacts on Protected Groups

Protected Group	Specific impact	Mitigating Action
Age	Older people may benefit more from increased integration between health and social care services as they may be more regular users of these services. Older people are more likely than others to take part in democratic processes so may participate more in local HWBs. But some older people may be less able to take part due to disability, unless they have someone to represent their views and needs.	Local authorities, through local HWBs and the JHWS, will be expected through their public sector duty to engage fully with older people and their representatives in producing JSNAs which take account of their needs and wishes.
Disability	Disabled people may benefit more from increased integration between health and social care services as they may be more regular users of services. But they may be less likely or able to take part in local democratic processes such as HWBs and some may need others to represent their views and needs.	Local authorities, through local HWBs and the JHWS, will be expected through their public sector duty to engage fully with people with disabilities and their representatives in producing JSNAs which take account of their needs and wishes.
Gender reassignment	Lack of evidence of specific impact. But involvement in the JSNAs and JHWS should ensure that services better represent the needs of people undergoing gender reassignment, so should be a positive impact. This is a very small group within the general population ⁹⁰ , so their needs may not be seen as overall high priority, which could be a negative impact.	Local authorities, through local HWBs and the JHWS, will be expected through their public sector duty to engage fully with people undergoing gender reassignment in producing JSNAs which take account of their needs and wishes. Better data collection will help to inform JSNAs.
Pregnancy and Maternity	Lack of evidence of specific impact. But involvement in the JSNAs and JHWS should ensure that services better represent the needs of pregnant women and mothers, which is a positive impact. The needs of pregnant women and mothers with other protected characteristics should also be better understood and met, which will be positive.	Local authorities, through local HWBs and the JHWS, will be expected through their public sector duty to engage fully with pregnant women, mothers and their representatives in producing JSNAs which take account of their needs and wishes.
Race	Involvement in the JSNAs and JHWS should ensure that services better represent the needs of people of different races: this will have a positive impact.	Local authorities will be expected to develop good practice based in guidance including Race for Health and Shared Intelligence, 'Joint Strategic Needs

⁹⁰ See Overarching evidence base for EIAs (Annex G) which begins on page EIA 151.

	<p>People from some racial groups may find it more difficult to take part in local democratic processes such as HWBs</p>	<p>Assessment – ‘Towards Culturally Responsive JSNAs’. August 2010⁹¹</p> <p>Local authorities, through local HWBs and the JHWS, will be expected through their public sector duty to engage fully with people of different races in producing JSNAs which take account of all races’ needs and wishes equitably, including adapting information and processes to enable their participation.</p>
Religion or belief	<p>Lack of specific evidence- although involvement in the JSNAs and JHWS should ensure that services better represent the needs of people of different religion or belief, which will be a positive impact.</p>	<p>Local authorities, through local HWBs and the JHWS, will be expected through their public sector duty to engage fully with people of different religions and beliefs in producing JSNAs which take account of their needs and wishes.</p>
Sex	<p>Women are much less likely than men to take part in local democratic processes, so unless this is addressed there may be a negative impact as JSNAs and JHWS may not take sufficient account of women’s needs.</p>	<p>Local authorities, through local HWBs and the JHWS, will be expected through their public sector duty to engage fully with women and men in producing JSNAs which take account of their needs and wishes.</p>
Sexual orientation	<p>Lack of specific evidence- although involvement in the JSNAs and JHWS should ensure that services better represent the needs of people of different sexual orientation.</p>	<p>Local authorities, through local HWBs and the JHWS, will be expected through their public sector duty to engage fully with people of different sexual orientations in producing JSNAs which take account of their needs and wishes.</p>
Socio-economic status	<p>People from some socio-economic groups may be less likely than others to take part in local democratic processes such as HWBs, so their needs may not be fully reflected in JSNAs and the JHWS. This will be a negative impact unless it is addressed.</p>	<p>Local authorities, through local HWBs and the JHWS, will be expected through their public sector duty to engage fully with people of all socio-economic groups in producing JSNAs which take account of their needs and wishes.</p>

⁹¹ http://www.raceforhealth.org/news/archive/2010/11/19/race_and_equality_jsnas_towards_culturally_responsive_jsnas

References

No.	Legislation or publication
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3	"The White Paper" – <i>Equity & Excellence: Liberating the NHS</i> http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353
4	'Liberating the NHS: Increasing democratic legitimacy in health', 2010, http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH_117586
5	The Government's Response to the White Paper <i>Equity & Excellence: Liberating the NHS</i> http://www.dh.gov.uk/en/Healthcare/LiberatingtheNHS/DH_122624
6	'An information revolution: A consultation on proposals', 2010, http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_120080
7	'Liberating the NHS: Greater choice and control. A consultation on proposals,' 2010, http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_119651
8	'Structural Reform Plan' 2010 Department for Communities and Local Government http://www.communities.gov.uk/publications/corporate/structuralreformplan
9	Dalziel, D., Hewitt, E. and Evans, L. (2007) <i>Motivations and Barriers to Citizen Governance</i> , London: Communities and Local Government. Haberis, A. and Prendergast, J. (2007) <i>Research Report 1. Incentives and Barriers to Becoming and Remaining a Councillor: A Review of the UK Literature</i> , London: CLG.
10	Hands, D., Taylor, S., Featherstone, R. and Bovaird, T. (2007) <i>Research Report 2. Understanding the Barriers and Incentives to Becoming or Remaining a Councillor in England</i> , London: CLG.
11	Duty to promote democracy (2009) Department for Communities and Local Government http://www.communities.gov.uk/documents/localgovernment/pdf/1306186.pdf
12	Real Involvement: Working with people to improve services (2008) Department of Health http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_089787
13	NHS Act 2006

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Equality Impact Assessment

Annex D: Liberating the NHS – HealthWatch

Introduction

D1. The aim of this policy is to set up Health Watch, a local and national patients' champion to make sure that patient's voices are heard about the issues they have in accessing, using and benefitting from health and social care. This should give an opportunity to address equality issues since patients with protected characteristics and their representatives will be able to use this channel to voice problems and suggestions for improving the care they need and receive. The problems that HealthWatch aims to address are that:

- Frontline clinicians and Healthcare service managers can have differing opinions regarding what constitutes a good quality service for the end user. This situation can lead to user needs and expectations not being fully met, and has the potential to lead to health inequalities.
- Some people lack the information and/or skills to make choice of local health care services (around 500,000 people currently use the Primary Care Trust Patient Advice and Liaison Service each year) and complain when a service does not meet their expectations/acceptable standards (around 13,000 use the Independent Complaints Advocacy Service each year).

D2. Addressing these aims, the objectives for HealthWatch are to:

- To give people a real input into decision making about the shape of health and care services, both nationally and in local communities.
- To ensure that (where necessary) people are supported to make choices and complain about health and care services.
- To reduce variation across England in access to these services and the chance of an issue about an individual's care being addressed. This should in turn address health inequalities and lead to a better patient experience, improved health for people and increase the cost effectiveness of services.
- To reduce the likelihood of significant adverse events, such as high mortality rates at a specific hospital.

D3. To deliver on these aims, HealthWatch England will be set up as a statutory committee of the Care Quality Commission (CQC), with a role in representing, at a national level people, using health and social care services. This will give people a real influence over policy, service planning and delivery.

D4. Local HealthWatch will be the local consumer champion across health and social care. They will retain Local Involvement Networks' (LINKs) existing responsibilities to promote patient and public involvement, and to seek views on services which can be fed back into local commissioning. They will have additional functions and funding, for providing complaints advocacy services and for supporting individuals to exercise choice.

D5. Local authorities will fund local HealthWatch and contract for their services. Each local authority will have to establish a health and wellbeing board covering health, public health and adult social care. The board will include a Local HealthWatch representative, to ensure that feedback from patients and service users can influence and shape commissioning plans.

Relevance to Equality and Diversity

D6. The purpose of this equality impact assessment (EIA) is to inform development of this policy so that, as far as possible, it:

- (v) Eliminates discrimination and does not generate or exacerbate inequalities in access to healthcare or health outcomes for patients and the public or employment and progression opportunities for actual/potential employees;
- (vi) Supports local efforts to reduce inequalities, promote equality and foster good relations between people from protected groups and those who are not.

D7. In carrying out this assessment, we have considered the following dimensions:

- Age
- Disability
- Gender reassignment
- Pregnancy and maternity
- Race or ethnicity
- Religion or belief
- Sex
- Sexual orientation
- Socio-economic status

D8. We have chosen to include all the relevant protected characteristics covered by the Equality Act in accordance with good practice guidance from the Equalities and Human Rights Commission (EHRC). Not all the provisions of the Equality Act are yet in force; some, such as the prohibition on age discrimination in services and public functions are still under consideration, and the public sector equality duty is due to commence in April 2011. Our consideration of these characteristics takes into account that we expect these measures to be in force when these provisions come into effect.

D9. Socio-economic status is not one of the protected characteristics that must be covered in the public sector equality duty and therefore in the EIA, but has been included for completeness of impact on current health inequalities.

D10. HealthWatch England, as a sub-committee of the CQC will be subject to the Equality Act 2010 (general and specific duties). Local HealthWatch may be procured by Local Authorities through other organisations such as voluntary, charity or community, or private sector organisations. The Equality Act duties in relation to public functions will apply to private providers on the basis that they are providing a function of a public nature

D11. The independent scrutiny role is to get views that are representative of the communities they serve. There is a danger that they focus on a much narrower set of views that then skew the commissioning and delivery of health and care services towards the most articulate members of society – widening health inequalities. Voluntary services on their own have had difficulty in collecting, analysing and delivering reports and recommendations to commissioners, which has meant little change to services in their area. An organisation like local HealthWatch gives a focus for these views and a means by which they are more likely to be effective.

D12. Where done through web based information sites, such as NHS choices, providing support for making complaints and making health related choices is relatively inexpensive. However, these won't deliver for some members of society. Web based information sites are disabling for some people, for example, people for whom English is not their first or preferred language for communicating and people with impairments that are incompatible with information technology. Face to face or telephone support, which is required for some people, is a relatively resource intensive work, but can significantly improve people's experience of care and confidence in providers to deliver this good experience.

The Equality Act 2010 and Powers of the Secretary of State

- D13. The Equality Act aims to simplify, harmonise and strengthen equality law, replacing nine major pieces of legislation and around 100 other instruments with a single Act. It received Royal Assent on 8 April 2010. The main provisions in the Act came into force in October 2010 and the single public sector equality duty will come into force in April 2011⁹².
- D14. The single public sector equality duty covers race, disability, and gender (existing duties), plus age, sexual orientation, religion or belief, pregnancy and maternity, and gender reassignment. These dimensions are collectively referred to as the protected characteristics. All public bodies, including those changed or set up through these provisions, must have due regard to the need to:
- eliminate unlawful discrimination, harassment, and victimisation;
 - advance equality of opportunity; and
 - foster good relations between those who share a relevant protected characteristic and those who do not.
- D15. This general duty is underpinned by specific duties, to help public bodies meet the general duty. The Government has recently undertaken a public consultation on the specific duties.
- D16. The Equality Act 2010 will ensure that all public bodies within the health service, including the NHS and the public health service, are obliged to comply with principles of equality.

Summary of Evidence

- D17. This EIA relies on evidence and stakeholder feedback to:
- provide supporting evidence where actual or potential impacts on equality and human rights were identified
 - assist with developing proposals for mitigating potential negative impacts
 - demonstrate how proposed reforms can promote equality and human rights, where possible
- D18. Table 2 summarises the evidence on access to health services and health outcomes by protected characteristic. This section outlines the available evidence on the impact of HealthWatch on equality.
- D19. Evidence in the overarching equality impact assessment for the Health and Social Care Bill gives an assessment of differences in access to, experience of and quality of care across different equality groups. HealthWatch is set up to address three key objectives that underpin these overall outcomes, namely (1) give people a real input into decision making about the shape of health and care services (2) support people to make choices and (3) support people to complain. Each objective is assessed below.

Input to decision making

- D20. To be successful, local HealthWatch needs active volunteers who have the skills to engage with all parts of society and to prioritise on the basis of community need (the average LINK had over 50 active volunteers in 2009-10). It also needs awareness of routes for raising issues, easy ways to do this that are accessible to all.

⁹² From April 2012, the ban on age discrimination in provision of goods, facilities, services and public functions will be implemented.

- D21. There is no difference in active participation in helping to shape health services between men and women (source: Citizenship Survey, 2008-09). Survey numbers are too small to be definitive about participation of people from different ethnic groups or religions, though the data suggests no difference by ethnic group, but people from Hindu, Sikh and Muslim faiths have higher participation in shaping health services than those from a Christian faith (Hindu 2.8%, Sikh 2.6%, Muslim 1.6%, Christian 1.3%). The survey suggests that people from different ethnic backgrounds have similar levels of participation. Older people are more likely to participate (0.8% of under 30s participated, compared to 1.5% of over 50s), though this may be related to their use of services. Similarly, people with a long-term health condition are more likely to participate than those who don't (1.9% vs. 1.2% respectively). There was no evidence based on whether someone was pregnant or a new mother. Feedback to the white paper was that the lesbian, gay, bisexual and transgender communities report that GPs do not include or engage them in decision-making. There was no other evidence for these groups.
- D22. Reasons for non-participation were similar for people from different ethnic groups or faiths and between men and women. However, people with a disability and older people were more likely to have said that not being able to give opinions on-line was a barrier and older people also were more likely to say that a lack of time stopped them participating.
- D23. The main reasons people got involved were:
- They were asked directly to do this (44% mentioned this)
 - A desire to serve the community (41% mentioned this)
 - Wanting to improve local services (41% mentioned this)
 - A desire to "have my say" (29% mentioned this)
- D24. While these reasons were common to people from different backgrounds, someone was more likely to be asked if they were White-British (46% versus 27% for non-white ethnic group), older (47% of over 65s vrs. 37% under 30s) and be from Christian faith (45% versus 25% of people of other faiths). A desire to improve local services or the community was higher amongst people from non-white ethnic groups (39% white-British/Irish, 52% non-white-British/Irish), amongst older people (25% for under 30s, 44% for those 50+) and for people from non-Christian faiths (43% for Christians, 59% for people from other faiths).
- D25. There are no differences in wider engagement with shaping health and care services by gender, age and disability. White British people are slightly more likely to be involved (21% versus 16% for people from BME groups) and Christian or Buddhist people are more likely to be involved (21% versus 12% for Hindus, 14% for Sikhs and 17% for Muslims), suggesting there is potential for promotion of equality between races and between religions. There was no evidence based on whether people were pregnant or a new mother. Feedback to the white paper was that the lesbian, gay, bisexual and transgender communities report that GPs do not include or engage them in decision-making. There was no other evidence for these groups.
- D26. LINKs were set up to engage and involve in decision making a representative section of the community. Statistics on the characteristics of LINK members was reported for the first time in 2009-10 annual reports. Only 19 of the 151 LINKs were able to provide this data. It showed that LINKs had engaged with different parts of society. They had good cross sectional membership. The groups they engaged with tended to be on specific issues (e.g. one LINK reported large numbers of people from BME groups, deaf people and students), but the focus was dependent on local analysis of the problems facing that community. LINKs employed a range of engagement techniques that seemed to mitigate against risks of missing particular segments of the population. The intention is that HealthWatch will be at least as good as LINKs in engaging with all parts of

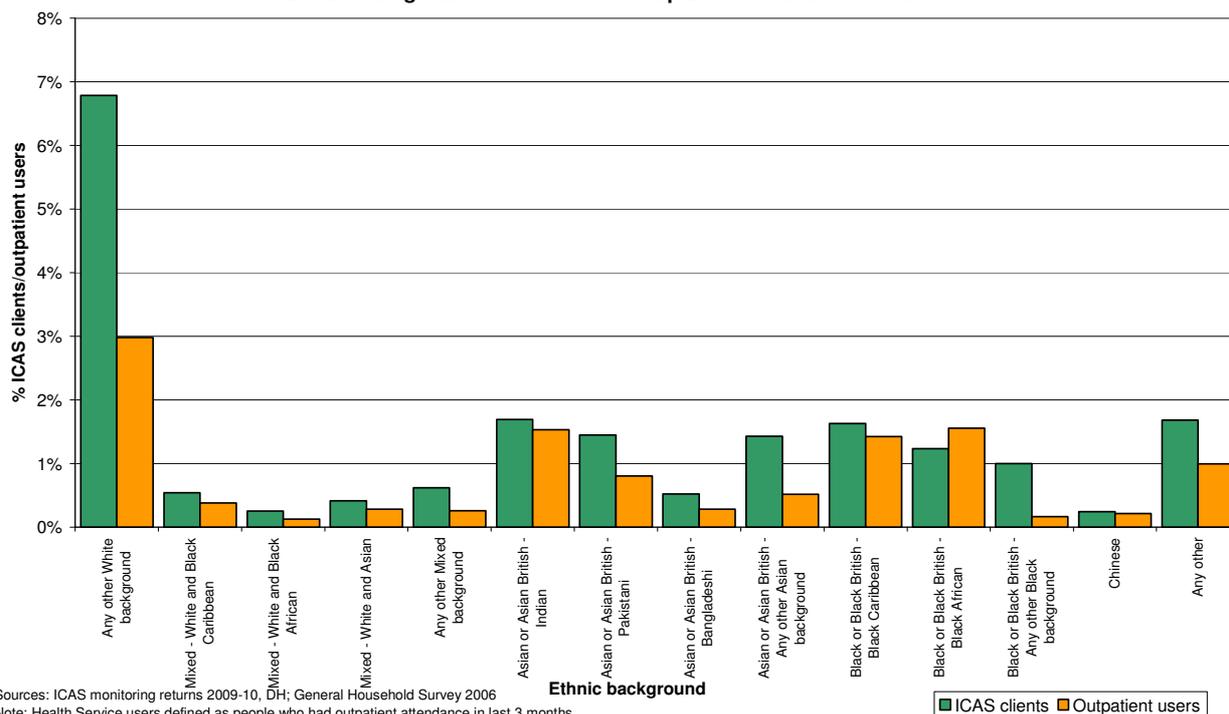
the local community so that in future engagement and data collection will be improved. Therefore, local HealthWatch should be able to improve their evidence of ways in which they represent equality groups.

- D27. Analysis of the LINks annual reports 2009-10 showed no differences in the activity of or outcomes from LINks in areas with different socio-demographic characteristics. There was a relatively weak link with rurality in that LINks in rural areas tended to deliver slightly lower levels of service change compared to LINks in urban areas. It is important that local HealthWatch maintains a range of ways it engages with the public (tailored to local populations) and that funding takes account of rurality.
- D28. The HealthWatch Impact Assessment (beginning on page 85) gives evidence on the link between people being engaged and improvements in the quality and experience of health and care services and their value for money. In addition, people who are engaged in community activity tend to have better health themselves as a consequence (Source: "Social Capital: Measurement and Consequences", Robert Putnam). Existing mechanisms are generally good at involving and engaging people from different communities, therefore contribute to reducing health inequalities. One area for improvement is increasing the influence of children and young people.

Advocacy for complaints

- D29. Compared to people who used hospital outpatient services, Independent Complaints Advocacy Service (ICAS) users were less likely to have a long-term health condition, are more likely to be adults and are more likely to be from a white, non-British ethnic background (sources: General Household Survey, 2006 and ICAS monitoring statistics 2009-10). While not explicit, the high proportion of white-non British people suggests ICAS helps overcome language barriers to making complaints and help people newly arrived in this country who may be unaware of their right to complain – see chart below.
- D30. Despite recent improvements (see "Progress report on six lives", Department of Health, October 2010 <http://www.parliament.uk/deposits/depositedpapers/2010/DEP2010-1816.pdf>), there is evidence (especially the Mencap report 'Death by Indifference') that learning disability does place some complainants at a disadvantage. Additionally users with long-term mental health difficulties may also need specific/specialist support or representation throughout the process. Speech/communication difficulties may also lead to a reluctance to complain.
- D31. The equality impact assessment on reform to the complaints system (Department of Health 2009) found anecdotal evidence that, where the complaint is of a sensitive or intimate nature, complainants/service users may express a need or preference to work with either a male or female advocate in order to progress their complaint. Cultural customs or religious codes of behaviour may lead to difficulties in pursuing a complaint. For example, women of South Asian heritage may be unwilling to discuss sensitive or intimate issues with male staff and this can be compounded if they cannot speak English and the interpreter is male. However there is no evidence of differences in need for services between men and women.

Ethnic background of ICAS users compared to health service users



D32. Therefore, there is significant scope to better focus advocacy services on people with a disability or long-term condition and providing help for children⁹³.

D33. There is no evidence of need for or use of advocacy services based on religion, on sexual orientation, on whether people were pregnant/new mothers, were from different socio-economic groups or on whether they had undergone gender reassignment. Addressing this is in the Department’s action plan at the end of the equality impact assessment

Support for choice

D34. Home movers are the biggest group of people making choices about switching GP practice or dentistry services. The majority of these people are under 35 (54% total), with 10% being over 65 (source: General Household Survey, 2006). Different people value different things from primary care. See GP practice boundaries impact assessment for more details⁹⁴. Having information on the range of services available in different practices, should allow better allocation of people to the services that best meet their needs. It should also act as an incentive for improvement to individual service providers.

D35. People in rural areas tend to have a much lower choice (31% in rural areas said they have little choice of GP practice compared to 6% in urban areas, source: primary care tracker survey, Ipsos MORI, 2010), but there is no evidence that people in rural areas are more or less supported to make choices than those in urban areas.

D36. People from social classes A/B are more likely to be aware that information on choices can make a difference to the care you receive and your health (32% versus 19% of people from social class

⁹³ A representative is able to make a complaint on behalf of a child (someone who has not attained the age of 18) only where there are reasonable grounds for the complaint being made by the representative instead of the child".

⁹⁴ http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Consultations/Liveconsultations/DH_113437

D/E). There is no significant difference in use of information for making choices about care by gender (though see below about the use of the PALS service in PCTs by women), age, social class or disability. However white-British people are more likely to say using this information benefited them (5% versus 0% of people from BME groups) (source: primary care tracker survey, Ipsos MORI, 2010). There was no evidence about other socio-economic characteristics of the population.

- D37. Feedback to the white paper was that the lesbian, gay, bisexual and transgender communities report that GPs do not include or engage them by offering choice making. There was no other evidence for these groups. There was no evidence on the need for support for health care choices or the extent to which this is currently delivered based on a person's religion or on whether someone is pregnant or a new mother.
- D38. Evidence on the PALS service in PCTs is the main source around support for choices. No national data is available about the socio-demographic characteristics of its users, however, details were published for one PCT PALS (Sutton & Merton). This showed that the service was used significantly more by women than men, but the ethnic group of users fitted the population profile well. It was used by more younger people than older people, though relative to the profile of people moving GP practice, more older than younger people used this service (26% were under 35 and 23% were over 65).
- D39. 88% of queries received by Sutton and Merton PALS were from people where English was their first language. This is relatively representative of their population, but fewer than expected people who predominantly spoke other languages, as they may be less likely to have alternative routes for information. This particular PALS has access to telephonic interpreting services, face to face interpreting service and British Sign Language interpreters. It is important these services continue to be offered, plus there is potential to use social marketing to target people who predominantly spoke other languages.
- D40. There is no national data about the way PALS queries are raised, but the proportion varies from 50%-75% of queries made on phone and 18%-33% via e-mail. Given low internet use by older people, it is important to maintain phone access.
- D41. More evidence around equality issues associated with choice in healthcare was published in the consultation "Liberating the NHS: Greater choice and control" launched in October 2010⁹⁵.

Existing good practice

- D42. There are many examples of where LINKs activity has delivered benefit to different parts of society. The issues chosen depend on analysis of local needs and are published in LINK annual reports, many of which are published on local LINK websites. Four examples of this good practice are presented in Appendix D1:
- Stockton on Tees – services for travelling communities
 - Sutton LINK – healthcare for new migrant workers
 - Stoke LINK – Male circumcision in Muslim families
 - Manchester LINK - Homeless people being heard

Impact on staff

- D43. There is no information covering the number of staff currently employed in the functions that will move to HealthWatch. A best estimate is that there are 330 people employed in the Independent Complaints Advocacy Service, 410 people employed in Primary Care Trusts providing a service giving information to support choice and 450 people employed to support Local Involvement Networks.
- D44. Each of these three services has a different contractual situation. We will need to work through the implications of this to establish how local HealthWatch will be staffed. To encourage diversity of local HealthWatch staff, HealthWatch England can offer guidance on equality recruitment issues.
- D45. The proposals will involve extra money to cover lost economies of scale in providing complaints advocacy and money to support an expected increase in demand for support for choice services. While decisions around staffing are for local HealthWatch to decide, this may mean an additional 100 staff are employed.
- D46. In addition, there will be staff employed directly by HealthWatch England and potentially contracted by them carry out duties which include support to local HealthWatch.
- D47. An estimated 69,000 volunteers have been participating in Local Involvement Networks, of which 7,900 are regular and active volunteers (source: LINKs annual reports 2009-10). Given the scale of volunteers, relative to employed staff in HealthWatch, it will clearly be important for HealthWatch to maintain and attempt to grow the volunteer role. Disclosure of personal details (such as protected equality group characteristics) has been seen to be a barrier to participation. As a result details of personal characteristics have not been collected from most people who have participated in this work and we have to rely on national survey data to give a picture of participation across society. A compromise way forward is to ensure that local HealthWatches report case studies of where their work has specifically engaged with and acted upon views from seldom heard groups, in a way that doesn't use personal information without the consent of the individuals concerned, which addresses the engagement of HealthWatch with seldom heard groups. In addition Health Watches could communicate and explain better .the need for collection of equality group characteristics to potential volunteers, to gain the understanding and if possible better co-operation and involvement of a diverse range of people able to represent local communities fully.

Summary of Stakeholder Feedback

- D48. A range of activities were undertaken to engage patients, the public and health and social care staff in helping to shape the proposals to establish HealthWatch. These activities included:
- Raising awareness of the proposals using a variety of communication channels such as Department of Health bulletins, news media, third party newsletters (e.g. voluntary and community organisations) and on-line communities of interest.
 - National events to either brief and get feedback from key representative organisations or large scale events to engage a wider cross section of patient and community and staff groups
 - One-to-one meeting with key stakeholders to get their views on the proposals
 - Regional events for both community and patient groups, as well as staff to explain and explore the proposals
 - On-line engagement using 'webinars' and forum discussions

- Workshops with key audiences (such as patient participation groups and local involvement networks members)

D49. In addition to this activity, LINKs themselves were encouraged to engage their local communities on the proposals and to feedback their findings. We also asked national organisations that represent specific groups to engage those they represent on the proposals.

D50. This led to a significant number of responses from a wide range of organisations about the design of HealthWatch and equality issues related to this. A selection of the relevant comments are given below. Further details of who was engaged, what they told us and how this fed into decision making is given in chapter 2 “Putting patients and the public first” of the Command paper *Liberating the NHS: Legislative Framework and Next Steps*⁹⁶ that was published in December 2010.

D51. Analysis of these comments (given their volume) will continue, with a network of stakeholders ensuring the development of HealthWatch continues to be informed in a spirit of co-production. By analysis of the comments, we should be able to identify gaps in the organisation engaged so far. It is our intention to try and fill gaps going forwards. As such, we will be holding further stakeholder events on planning the next steps of developing HealthWatch. We will, therefore, be inviting a cross-section of these organisations to represent their affiliated interests so that local HealthWatch develops into organisations that will begin to fulfil their Equality duties e.g. through influencing commissioning.

Table D1: Summary of relevant comments from engagement and consultation activity

<i>Organisations</i>	<i>Issues and Barriers</i>
AgeUK Breast Cancer Campaign National Children’s Trust	These organisations raised specific human rights issues raised for older people, women, parents and BME minority groups. <i>For example:</i> Age UK report of widespread age discrimination by Local Authorities when older people are the largest users of health and social care.
Afiya Trust Genetic Alliance Race Equality Foundation Samaritans Women’s National Commission	These organisations raised multiple human rights issues where multiple marginalisation creates greater challenges for involvement and engagement with vulnerable and seldom heard groups. These barriers impact on their lives and access to health and social care services. <i>For example:</i> Samaritans report that GPs do not have the knowledge and skills to commission for people who self-harm or considered at suicide-risk. The Race Equality Foundation add that GPs lack of know-how about culture and community and their specific disease and conditions add these barriers.
Bradford Learning Disabilities Partnership GLADD Learning Disability Federation NE and the ‘Elevenses’ Group Lesbian and Gay Foundation	These organisations raised all human rights issues where commissioners and providers made assumptions that are not accurate nor does it reflect their health and social care needs. These groups of people feel invisible to the health and social care ‘lens’ and are concerned that the pace of change proposed by the structural changes would place these seldom heard groups further away from having a voice.

⁹⁶ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122661

<p>Mencap National Lesbian, Gay, Bisexual and Transgender Partnership RESPECT Royal Borough of Windsor and Maidenhead Learning Disabilities Partnership Board REACH Stonewall West Norfolk Disability Information Services</p>	<p><i>For example:</i> The Lesbian, Gay, Bisexual and Transgender communities report that GPs do not include or engage them by offering choice and in decision-making. The Learning Disability communities add that the commissioning process and GP consortia are not clear raising some anxiety about what this means in practice.</p>
<p>Leicestershire Partnership Men's Health Forum Youth Access</p>	<p>These organisations raised issues about how human rights can be fulfilled with hard to reach groups.</p> <p><i>For example:</i> Men's Health Forum report that men see barriers to health i.e. designed for women who naturally need to seek healthcare e.g. through pregnancy and, therefore, men do not seek medical attention unless they are in considerable pain or have a serious condition.</p>

Discussion of potential impacts

D52. Issues affecting all different parts of society are:

- **Independent scrutiny role:** Disclosure of personal details (such as protected equality group characteristics) has been seen to be a barrier to participation. As a result details of personal characteristics have not been collected from most people have participated in this work and we have to rely on national survey data to give a picture of participation across society. A compromise way forward is to ensure that local HealthWatch organisations report case studies of where their work has specifically engaged with and acted upon views from seldom heard groups, in a way that doesn't use personal information without the consent of the individuals concerned.
- **Leadership:** HealthWatch England will need to be seen as a leader for the local HealthWatch organisations. Therefore having a diverse membership for the HealthWatch England committee will be important in helping both local and national HealthWatch deliver for the communities they serve. Given HealthWatch England will be an independent committee of the Care Quality Commission, it should be able to draw upon the experience the Care Quality Commission has in equality issues.
- **Greater public awareness.** This is likely to reduce inequalities as a result of more people engaged in shaping healthcare services and people being supported to make complaints. The risk here is that the majority begin to crowd out people that benefit most from these services, with mitigation that it will be important for local HealthWatch to improve awareness of their service to particular parts of community, particularly young people and people with a disability.
- **Temporary reduction in output during change.** Given these policies currently support reduction of health inequalities, this risk will work against equality in the short term. In policy development, we should consider how best to maintain continuity, both experience and established relationships with community groups.
- **Introduction of face to face support service.** The impact of this (if offered) depends upon the location. If positioned right, this may help local HealthWatch target its services, though it would be difficult to achieve consistency of service between rural and urban areas.

- **Health literacy:** As well as giving people one off advice on choices, there is the opportunity to develop other ways of enhancing health literacy in communities to reduce demand for this support in the longer term.

Age

- D53. From analysis of ICAS user data, advocacy for complaints does not appear to be adequately focussed on children. In addition, young people are involved significantly less than older people in shaping health and care services (from Citizenship survey). Perhaps linked to this, young people report poorer experiences of using health services in many different settings (e.g. at GP practice, in hospital – see Department of Health report on GP patient survey and Care Quality Commission patient surveys). To ensure that local HealthWatch services deliver better for younger people and mitigate the risk that extra funding for NHS complaints advocacy services does not narrow these inequalities, they need to market their offer appropriately and be accountable, through management information, to the local authority and populations they serve. The Department's expectation is that this will happen and that there will accordingly be a positive impact on age.
- D54. As people who move home tend to be younger adults, this group should gain in particular from increased number of people being supported to make choice of different types of primary care provider. However, older people should also benefit. This group are less likely to have access to online support for choices and will benefit from greater support on the phone or in person. With greater parity expected between younger and older people in benefiting from support for choices the Department's view is that the policy will have a positive impact on age
- D55. The issues affecting all parts of society equally apply for age (see paragraph D52). Therefore, there may be potential benefits: opportunities for improving health literacy and greater public awareness reaching a wider community. However, potential risks are in short term disruption to the delivery of benefits, and those needing services being crowded out. These issues are addressed in the Department's action plan in paragraph D79.

Disability

- D56. There is no significant difference in use of information for making choices based on disability. Therefore, the policy is unlikely to have either a positive or negative impact on disability in this regard.
- D57. There is evidence that people are more likely to have participated in decision-making if they have a long-term condition. It is likely that this trend will continue. In this regard, the policy will have neither a positive nor negative impact on disability. However, with scope for more people to be engaged in shaping services it is to be expected that the policy will also help promote equality by encouraging people without long-term conditions to also participate in decision-making.
- D58. Advocacy for complaints does not appear to be adequately focussed on people with a disability (including learning disabilities and people with long-term conditions). To ensure that local HealthWatch services deliver better for people with a disability, they need to market their offer appropriately and be accountable, through management information, to the local authority and populations they serve. The Department believes this will happen with better leadership and training, and mean that there will be a positive impact on disability.
- D59. The issues affecting all parts of society equally apply for disability (see paragraph D52). Therefore, there may be potential benefits: opportunities for improving health literacy and greater public awareness reaching a wider community. However, potential risks are in short term

disruption to the delivery of benefits, and those needing services being crowded out. These issues are addressed in the Department's action plan in paragraph D79.

Ethnicity

- D60. Despite good equality in participation in independent scrutiny, white British people are more likely to be asked to participate than people from minority ethnic groups. Centrally defined standards and training may address this apparent behaviour. This is important in all functions of HealthWatch, both for employed staff and volunteers to minimise avoidable variations in the quality of services and their impact.
- D61. Reported experience of patients from black and minority ethnic groups is on average worse than that of white British people. So, given gains expected from the independent scrutiny role of local HealthWatch are focussed on improving patient experience, there is the potential for HealthWatch contributing to closing the gap in current inequalities. The Department's view therefore is that the policy will have a positive impact on ethnicity in this regard.
- D62. Given people whose second language is English are more likely to need support for making choices and advocacy to complain, it is important that HealthWatch continues existing interpretation services for these people to avoid unequal opportunities emerging. The Department believes this will happen with better leadership and training. Therefore, the Department's view is that the policy will not have a negative impact on equality. Further, by closing the gap between this group and others as regards outcomes, it is expected that the policy will have a positive impact on equality.
- D63. The issues affecting all parts of society equally apply for ethnicity (see paragraph D52). Therefore, there may be potential benefits: opportunities for improving health literacy and greater public awareness reaching a wider community. However, potential risks are in short term disruption to the delivery of benefits, and those needing services being crowded out. These issues are addressed in the Department's action plan in paragraph D79.

Gender reassignment

- D64. Data and research on trans health are limited but the evidence base is growing (see evidence in the overarching equality impact assessment for the Health and Social Care Bill). We know that transgender people are particularly vulnerable to discrimination and harassment, and also experience inequalities in access to healthcare and health outcomes. Feedback to the White Paper was that the transgender communities report that GPs do not include or engage them by offering choice or in decision-making. So, given that gains expected from the independent scrutiny role which local HealthWatch will be given are often focussed on improving patient experience, there is the potential for HealthWatch contributing to closing the gap in current inequalities. In addition, more capacity for complaints advocacy and support for choice is likely to benefit transgender people. Therefore, the Department's view is that the policy will have a positive impact on equality in this strand.
- D65. The issues affecting all parts of society equally apply for gender reassignment (see paragraph D52). Therefore, there may be potential benefits: opportunities for improving health literacy and greater public awareness reaching a wider community. However, potential risks are in short term disruption to the delivery of benefits, and those needing services being crowded out. These issues are addressed in the Department's action plan in paragraph D79.

Pregnancy and maternity

- D66. There is little published evidence about the use and experience of NHS advocacy, support for health service choices and independent scrutiny based on whether someone is pregnant or a new mother. Younger adults are more likely to move house each year and so are more likely to benefit from greater support for choice. However, there are likely to be limited other effects of introducing HealthWatch on pregnant women/new mothers compared to other people. On balance, the Department's view is that the policy will not have a negative impact on equality in this strand. However, with scope for more people to be engaged in shaping services, greater capacity for advocacy and improved support for choice, it is to be expected that there is scope for the policy to promote equality of opportunity.
- D67. The issues affecting all parts of society equally apply for pregnancy and maternity (see paragraph D52). Therefore, there may be potential benefits: opportunities for improving health literacy and greater public awareness reaching a wider community. However, potential risks are in short term disruption to the delivery of benefits, and those needing services being crowded out. These issues are addressed in the Department's action plan in paragraph D79.

Religion or belief

- D68. People from Hindu, Sikh and Muslim faiths have higher participation in shaping health services than those from a Christian faith (source: Citizenship survey). People from non-Christian faiths also have lower levels of reported experience of health services (sources include GP patient survey and Care Quality Commission patient surveys). Creating stronger routes for independent scrutiny to improve patient experience should reduce the current inequalities between religious groups. Therefore, the Department is of the view that the policy will have a positive impact on religion.
- D69. There is no evidence based on religion as regards NHS advocacy or support for choice, however based on the fact that people from non-Christian faiths have lower levels of reported experience, the Department is of the view that such people are also more likely to need help with NHS advocacy and support for choice. To mitigate the risk that extra funding for NHS complaints advocacy and support for choice services does not narrow potential inequalities, they need to market their offer appropriately to populations they serve. The Department's expectation is that this will happen and that there will accordingly be a positive impact on religion.
- D70. The issues affecting all parts of society equally apply for religion (see paragraph D52). Therefore, there may be potential benefits: opportunities for improving health literacy and greater public awareness reaching a wider community. However, potential risks are in short term disruption to the delivery of benefits, and those needing services being crowded out. These issues are addressed in the Department's action plan in paragraph D79.

Sex

- D71. There are no current significant differences between men and women in participation in decision making, and need for or outcomes from complaints advocacy or support for health related choices. There is nothing to suggest this would change as a result of the creation of HealthWatch. Based on this the Department's view is that this policy will not have a negative impact on gender. Further, as a result of more people engaged in shaping services and being supported to make complaints the Department's view is that the policy will help promote equality of opportunity for men and women.

D72. The issues affecting all parts of society equally apply for sex (see paragraph D52). Therefore, there may be potential benefits: opportunities for improving health literacy and greater public awareness reaching a wider community. However, potential risks are in short term disruption to the delivery of benefits, and those needing services being crowded out. These issues are addressed in the Department's action plan in paragraph D79.

Sexual orientation

D73. Evidence in the overarching equality impact assessment for the Health and Social Care Bill suggests that knowledge about use of health services is limited, though there is some evidence that lesbians, gay men and bisexual (LGB) people sometimes feel they cannot disclose their sexuality. Consequently, they may not get the same level of service as heterosexual/straight people. Feedback to the white paper was that lesbian, gay and bisexual communities report that GPs do not include or engage them by offering choice or in decision-making. So, given that gains expected from the independent scrutiny and support for choice roles, which local HealthWatch will be given, are often focussed on improving patient experience, there is the potential for HealthWatch contributing to closing the gap in current inequalities. Therefore, the Department is of the view that the policy will have a positive impact on equality in this strand.

D74. There is no evidence of how need for advocacy differs for lesbians, gay men and bisexual (LGB) people as compared to heterosexual/straight people. However as the policy is focussed on improving access to advocacy the Department's view is that the policy will provide an opportunity for promoting equality of opportunity.

D75. The issues affecting all parts of society equally apply for sexual orientation (see paragraph D52). Therefore, there may be potential benefits: opportunities for improving health literacy and greater public awareness reaching a wider community. However, potential risks are in short term disruption to the delivery of benefits, and those needing services being crowded out. These issues are addressed in the Department's action plan in paragraph D79.

Socio-economic group

D76. While people in lower socio-economic groups are slightly less likely to participate in health decision making activity, there is no difference in the activity or outcomes from LINKs in areas of different levels of deprivation. To maintain this moving into local HealthWatch, it is important that they are accountable for contributing to reducing health inequalities, through management information, to the local authority and populations they serve.

D77. There is no evidence about the need for or use/effect of NHS complaint advocacy by socio-economic group. However based on the fact that people from socio-economic groups D and E have lower levels of reported experience than those in groups A and B (sources include GP patient survey and Care Quality Commission patient surveys) and there is no difference across socio-economic groups in available health service choices, it is likely that that people from socio-economic groups D and E are also more likely to need help with NHS advocacy and support for choice. To mitigate the risk that extra funding for NHS complaints advocacy and support for choice services does not narrow these inequalities, they need to market their offer appropriately to populations they serve. In particular, they could be physically based in areas of higher deprivation. The Department's expectation is that this will happen and that there will accordingly be a positive impact on socio-economic groups.

D78. The issues affecting all parts of society equally apply for socio-economic status (see paragraph D52). This is particularly opportunities for improving health literacy (as this is strongly linked to socio-economic status) but also greater public awareness reaching a wider community. However,

potential risks are in short term disruption to the delivery of benefits, and those needing services being crowded out. These issues are addressed in the Department's action plan in paragraph D79.

Recommended Actions

D79. The main issues specifically on equality issues are identified below together with mitigating actions. They are in addition to the overall risks identified other actions included elsewhere in the impact assessment and equality impact assessment.

- (a) Advocacy for complaints does not appear to be appropriately focussed on children or people with a disability (including learning disabilities and people with long-term conditions). In addition, young people are involved significantly less than older people in shaping health and care services. Perhaps linked to this, young people report poorer experiences of using health services in many different settings (e.g. at GP practice, in hospital).
- (b) To encourage local HealthWatch to deliver better services for younger people (or other parts of society whom are currently less engaged/supported), they need to market their offer to these groups and be accountable, through management information, to the local authority and populations they serve. This suggests the need for refining the requirements for accountability and management data to fully take account of protected diversity groups.
- (b) Rural communities may find it more difficult to raise queries, be supported to make choices or complain. It is important that local HealthWatch maintains a range of ways it engages with the public (tailored to local populations) and that funding takes account of rurality.
- (c) While the evidence base is strong for particular aspects of the HealthWatch role and for certain parts of society, it is not comprehensive. To improve the extent to which the establishment of HealthWatch delivers for all equality groups, the Department of Health will need to fill gaps in evidence, particularly on pregnant women/new mothers, people having undergone gender reassignment and people of different sexual orientations.
- (d) DH will further consider the NHS White Paper consultation responses and support stakeholders to use this information to shape HealthWatch England and local HealthWatch. This will include addressing how local HealthWatch can engage more with groups such as children and those living in rural communities.
- (e) The Department of Health will need to work through the implications of existing staffing and contractual arrangements to establish how local HealthWatch will be staffed. To encourage diversity of local HealthWatch staff, the Department can ask HealthWatch England to offer guidance on equality recruitment issues.
- (f) The Department of Health will develop HealthWatch England (in collaboration with other stakeholders) in a way to minimise negative short term falls in productivity associated with the transition to local HealthWatch.

Table 2: Potential Impacts on Protected Groups

D80. The table summarises critical assessment made above for the policy for its impacts on protected groups, together with proposed mitigating actions or opportunities where equality and diversity can be promoted.

	IMPACT	MITIGATING ACTION
Age	Stronger mechanisms for driving change through independent scrutiny by HealthWatch is potentially a positive impact	Encourage HealthWatch England to include equality issues in training for local HealthWatch staff and volunteers
	Better funding for complaints advocacy and support for choice will have a positive impact on shaping services in line with patients' needs and wishes.	Help HealthWatch have immediate impact through appropriate marketing of their offer and strong accountability, through management information
	Better engagement with local communities and encouragement of a more diverse range of volunteers will have a positive impact in raising awareness of people's needs, but could have a negative impact if not comprehensive	HealthWatch to communicate and explain the use of equality characteristic data collection and use to improve services for all groups in a community
Disability	As for age	Accessible communication and information adapted to meet different needs will help participation by people with a range of disabilities
Race	As for age	Accessible communication and information adapted to meet different needs and awareness of cultural issues will help participation by people of different racial groups
Gender Reassignment	As for age	Acceptance and awareness of trans issues will encourage participation of trans people
Pregnancy and Maternity	As for age	
Religion or belief	As for age	Awareness of cultural issues will help participation by people of different religions or beliefs.
Sex	No positive or negative impact anticipated	
Sexual Orientation	As for age	
Socio-economic Status*	No positive or negative impact anticipated	

* Socio-economic status is not a protected characteristic but has been included for completeness of impact on current health inequalities.

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Appendix D1: case studies for LINKs

Example 1: Stockton -on- Tees LINK

The Issue: LINK Report on findings following issues raised by The Society for the Promotion and Advancement of Romany Culture

The LINK were contacted by the Stockton International Family Centre to ask for their help in ensuring that the travellers and gypsies from Stockton-on-Tees were supported in gaining access to health and social care services.

LINK activity:

LINK members met with two support workers from SPARC (The Society for the Promotion and Advancement of Romany Culture). The two support workers explained the Romany Culture and how they were reluctant to go and seek help from medical professionals. It was difficult for the Gypsies and Travellers to register with a GP because they had problems with the registration process and found it off putting. This meant they were not able to access Primary Care and Social Care Services and very often health problems became acute and would then require admission to hospital or go straight to the Accident and Emergency Department at the Hospital. This also often created problems as reception staff would need to know the name of their GP and postcode.

Additionally, the LINK learned of the problems in getting advice over mental health and social services and wanted someone they could trust to support them.

Outcomes:

The LINK Chair wrote to the Primary Care Trust (NHS – Stockton) and Stockton Borough Council with a report on their findings and recommendations. After meetings with the Primary Care Trust and Stockton Borough Council the following changes are being made:

Stockton Borough Council and NHS Stockton have funded a post through MIND for a Mental Health Community Development Worker to work with the Gypsy and Travelling Community

NHS Stockton have agreed to provide funding to support the work of SPARC so that the Gypsies and Travellers will have a contact point for help.

The NHS Stockton Public Engagement Officer now regularly visits SPARC to ensure there are no problems

Health cards are being issues to Gypsies and Travellers to show when they attend a healthcare service to overcome any literacy and registration problems.

Stockton LINK will continue to monitor progress but are very pleased that they have been able to help improve the access to health and social care services for Gypsy and Travellers in Stockton.

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Stockton-On-Tees LINK

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Example 2: Sutton LINK

The issue: Healthcare Needs of New Migrant Communities in the London Borough of Sutton

The background to this piece of research was that Sutton LINK was aware there were new migrants coming into the community specifically from Eastern Europe. There was also concern from Sutton and Merton PCT about the increase in use of Accident & Emergency as a first port of call by patients from these minority communities.

Aims:

The LINK sought to establish the healthcare needs of new migrant communities in Sutton, and make appropriate recommendations to Sutton and Merton PCT and other healthcare providers in order to meet these needs. A review of existing data and research with the diverse migrant groups was undertaken by the LINK. As a result of the research it is hoped that the Sutton and Merton PCT will have gained a clearer understanding of the healthcare needs of new migrant communities in Sutton and will be able to achieve appropriate changes and/or improvements. The research objectives were as follows:-

- Obtain PCT/NHS data about migrant communities in Sutton, and information about any specific healthcare services currently offered to these groups.
- Identify the major groups of new migrant communities in Sutton
- Establish the healthcare needs and use of health services by these communities
- Identify gaps or required improvements in services
- Produce a report with recommendations for the LINK

LINK Activity:

Discussions with the PCT/NHS revealed that data on ethnicity is not routinely collected by Accident & Emergency Departments. The only specific service provided for migrant communities within the PCT/NHS is the Language Line translation service. However, as a result of the research it would appear that some healthcare professionals do appreciate the cultural needs of communities. For example the cultural need of Tamil women to be seen by a female doctor.

In order to ascertain what the 'new' migrant community groups in the London Borough of Sutton were, it was necessary to draw together and examine data from a variety of sources:

- Schools data – Languages spoken by Ethnic Description - School Census (Primary & Secondary) - October 2008
- Department of Work & Pensions – National Insurance Number Allocations to Adult Overseas Nationals Entering the UK 2007/08
- Translation Requests
- Questionnaires entitled 'Healthcare Needs of the Tamil/Albanian/Polish/Bulgarian Community in the London Borough of Sutton' were produced for these communities and introductions made with the Tamil and Albanian Schools in Sutton. Information drawn from responses to the Healthcare Questionnaire was analysed and used by the LINK to make recommendations for the report.

The recommendations are as follows:

- This report recommends that the London Borough of Sutton invests time and resources into setting up community groups for the Tamil, Polish, Albanian and Bulgarian communities in Sutton.
- Once these community groups are established they should be used regularly to disseminate information on healthcare and social services to members of those communities.

- This report recommends that Sutton and Merton PCT reviews its Translation Service with a view to promoting its existence more to new migrant communities and making it more easily accessible by members of the public.
- It is recommended that SMPCT looks into practices at GP Surgeries relating to the welcoming and registration of BME patients and particularly those from new migrant communities.

Outcomes:

The report was submitted by the LINK to the PCT and local authority. The report was used to support a successful PCT funding bid for external monies to provide assistance to help newly arrived communities in accessing health services. £30K was successfully secured with a further £10K available dependent on delivery.

The report was also used as supporting documentation for a tendering application by the PCT to the Migration Impact Fund.

A full copy of the research report is available from Sutton LINK. Contact Janice McCulloch, Sutton LINK Manager email: janice@suttoncvs.org.uk

Example 3: Stoke LINK

The issue:

The LINK was approached by a local community group with a petition containing 20,000 signatures from 1800 family leaders from Muslim families across Stoke-on-Trent and North Staffordshire about circumcision in young boys and information of a direct need from Muslim communities both resident and transient in the City.

This service is currently not provided on the NHS in Stoke-on-Trent, the PCT part commissions a service at Liverpool hospital, so 'back street' clinicians are used, and mistakes are made – thus leading to the need for further care. There is limited awareness and knowledge amongst this community about safe care. Discussion with the PCT shows that provision would need to be supplemented by parents at the cost of between £100 - £400.

There are nearly 18,000 Muslims in Stoke-on-Trent with approximately 300 births a year of Muslim children.

It is not within NHS Stoke-on-Trent's current budget plan to provide circumcision, however the information and communication can be improved, which goes to all families around circumcision.

LINK activity:

The LINK has looked at other Primary Care Trusts across the country, and current practice through 'Freedom of Information' letters.

The LINK is looking at improving the communication that goes out to families. This work is still in the early developmental stage. Numerous discussions have now happened with the PCT to ascertain what they are doing to improve communication with the Muslim community; the LINK is supporting this piece of work and will be consulting with community members on how effective the change is.

Ideally the LINK is hoping to influence commissioners to ensure a service is provided in Stoke-on-Trent. There is budgetary provision to support GP practices to develop a specific area in surgeries to undertake this practice; however no doctors in Stoke-on-Trent have taken this up to date.

Outcomes and Benefits:

Support from the LINK has highlighted the need for this service far greater than the communities had already achieved and has given a level of influence to this important issue not felt by the Muslim community prior to LINK involvement.

The LINK is working to address a direct need of community that is not being met. The LINK has gained evidence to substantiate the information gathered by the community about what happens elsewhere in the city, and the PCT recognise this is a problem in the City.

Conversations with the PCT show that they are not entirely comfortable with the LINK involvement in this area as the LINK is challenging the strategic direction of provision or lack of it in the City. This demonstrates that the LINK is fulfilling its primary role as an independent mechanism for seldom heard voices and is succeeding in raising awareness of the needs and priorities of under represented groups.

The contact made to the LINK by this large community, often considered as seldom heard, instead of the LINK contacting them, demonstrates that the LINK is gaining the trust of communities to take on issues

and that the LINK is championing direct concerns of the community. The LINK offers a mechanism for direct one-to-one contact with the community and acts as a facilitator between the PCT and community.

Example 4: Manchester LINK:

The Issue: Homeless people being heard

How did the campaign come about?

Manchester LINK put up a marquee in the city centre in October 2008 so that members of the public could find out about health and care services and ask the people in charge of services questions. Hundreds of people came along – some, it's fair to say, because we were providing food and drink. A lot of homeless people there had lots to say about the way they were treated by services. As a result of this event, the LINK Steering Group decided that the services homeless people receive should be a top priority.

LINK Activity:

Over the next year they spent a lot of time contacting community groups and organisations working in the homeless sector and getting their views on the key issues. Then, instead of just relying on organisations 'speaking for' homeless people they held also carried out a consultation activity, going out to service user drop ins, day centres and forums. As well as asking people what experiences they had of accessing health and social care services in Manchester, they also asked: if there were problems, what solutions they suggested for making things improve.

Setting up a 'task group'

The issues seemed to fit under different themes or headings. These themes were presented to a 'task group'. The task group was set up to give ownership to the different community groups, organisations and individuals with whom contact had been made since the start of this campaign.

The task group meets roughly every two months (they set the dates) and discussed the issues within the campaign. The task group examined the responses from the consultation and decided on four key pieces of work to be carried out. These were:

1. Mystery shopping GP services

Findings from the LINK consultation suggested that if people are perceived to be homeless (rough sleeping, sofa surfing, living in emergency accommodation etc) or state that they are homeless when trying to register as a new patient, sometimes GP surgeries will not take them on. They are either told that new patients are not being registered, patients are not being taken on from a particular hostel or that the surgery does not register temporary patients.

The LINK provided mystery shopper training for service users, (current or ex-homeless) who then went out to gather evidence on the way that GP services treat homeless people. The visits are all supported by LINK . They have also worked closely with NHS Manchester and the LMC to ensure that the mystery shopping activity was ethical and that we are measuring the correct set of standards set out in the GP contracts.

Outcomes:

The findings are being analysed by a LINK member who is carrying out his Masters Degree on homelessness and access to services. This analysis will be included in a report to be submitted to NHS Manchester in March 2010, with a set of recommendations. The response to the report will be published, and any changes monitored. It is likely that the LINK will carry out a follow activity in six months or a year's time to see if things have improved.

Staff Training DVD

Consultation responses suggested that people who are homeless do not receive the same level of dignity and respect from some staff across health and social care services.

The task group felt that one way to try and improve the understanding around the issues affecting homeless people, and hence the way they are treated by staff, was to produce a short film to be used as a training resource.

We put this piece of work out to tender and had several applications from community groups to produce this film. The Service User Network for homeless people is in the process of producing this DVD and is using service user involvement throughout the process. Homeless and ex-homeless service users have received training on how to use a video camera and also on how to interview people. They have planned the film, written scripts and performed in the film. It is scheduled to be completed by the end of March 2010. The film will be distributed throughout the statutory services who will be encouraged to use this as part of mandatory training.

NHS Manchester has received the idea of this film really positively and has already included it in their scheduling for future mandatory staff training. Discussions are underway on producing a pack to support the film and NHS Manchester will produce a budget for service users to create this. They will also pay for service users (as part of community groups) to deliver part of the training on an ongoing basis.

Equality Impact Assessment

Annex E: Liberating the NHS – The Department of Health’s public bodies

Introduction

- E1. The White Paper *Equity and excellence: Liberating the NHS* published in July 2010 made clear that over the next four years the Government is committed to reducing NHS administrative costs by more than 45% and to radically reducing and simplifying the number of NHS bodies, including the Department’s arm’s-length bodies.
- E2. It aims to create an Arm’s-Length Body (ALB) sector that achieves better outcomes, is more responsive to patients’ and service users’ needs with clear accountability at every level. In future, ALBs should only undertake functions that need to be done at arm’s length of the Department. Some functions may be transferred to other parts of the health and social care system, so that they are delivered at the most appropriate place in the system and those organisations that carry out functions that it is considered no longer need to be carried out are to be abolished.
- E3. This equality impact assessment (EIA) considers the impact on different groups of staff and service users of the proposed outcomes which were described in the review report: *Liberating the NHS: Report of the arm’s length bodies review*⁹⁷. This EIA also considers changes to the National Information Governance Board (NIGB) and JCVI.
- E4. As with the impact assessment, this EIA will look at the impact on equality of proposals relating to ALBs that are being provided for in the Health and Social Care Bill only. The bodies affected are:
- National Institute for Health and Clinical Excellence (NICE)
 - Care Quality Commission (CQC)
 - National Information Governance Board (NIGB)
 - Council for Healthcare Regulatory Excellence (CHRE)
 - General Social Care Council (GSCC)
 - Alcohol Education and Research Council (AERC)
 - NHS Information Centre (IC)
 - Appointments Commission (AC)
 - NHS Institute for Innovation and Improvement (NHSII) (leadership function only moving to NHS Commissioning Board)
 - National Patient Safety Agency (NPSA)
 - Joint Committee for Vaccination and Immunisation (JCVI)
- E5. The proposed changes of the ALB review that are provided for in the Health and Social Care Bill are:
- CQC, Monitor, IC and NICE have a clear future as ALBs but their functions will be changing to reflect the new system architecture. From paragraphs E31, E35 and E74 the impact of the changes to the NICE, CQC and IC respectively are considered. The expanding role of Monitor to cover economic regulation will be discussed in the Provision IA from page 28 of the Impact

⁹⁷

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_118053.pdf

Assessment document, so is not included here. The same applies to joint licensing between Monitor and CQC.

- CHRE will be moved out of the sector to operate on a full-cost recovery basis and have a new role in accrediting voluntary registers of certain health professionals and workers in the UK and social care workers in England. CHRE's role in overseeing regulators will be expanded to the regulation of social workers in England. The analysis of the impact of this proposal is considered in paragraphs E47-E56;
 - GSCC will be abolished and the role of the regulation of social workers will be transferred to an existing professional regulator. The analysis of the impact of this proposal is considered in paragraphs E57-70;
 - AC, AERC, NPSA and NHS III will be abolished or removed from the sector. However, this impact assessment will only cover the changes that require primary legislation in the Health and Social Care Bill; the abolition of AC and AERC, and functions of NPSA and NHS III being provided in future by the NHS Commissioning Board. The analysis of the impact of these proposals is considered in paragraphs E82-E86 and E87-105. The changes to other functions of the NPSA and NHS III will be dealt with separately;
 - The Department intends to transfer the functions of the HFEA and the HTA to other organisations by the end of the current Parliament in order to achieve greater synergies where appropriate, and the intention is to abolish these two organisations at that stage. The analysis of these proposals will be covered outside the Health and Social Care Bill, and will be covered in separate impact assessments and equality impact assessments in due course;
 - HPA will be abolished as a statutory organisation and its functions will be transferred to the Secretary of State as part of the new Public Health England (PHE). The analysis of this proposal and an assessment of the impact of this change is presented in Annex F.
 - The functions of the NTA will be transferred to the Secretary of State. The NTA will be abolished through secondary legislation in due course which will revoke existing statutory instruments, therefore it is not appropriate to do any further analysis in this impact assessment;
 - Section 250 of the NHS Act (2006) will be repealed in the Health and Social Care Bill. This will effectively remove the power from the Secretary of State to establish standing advisory committees in statute. One consequence of this would be the abolition of the Joint Committee on Vaccination and Immunisation (JCVI). However, the Bill includes a *saving provision* which maintains JCVI as a statutory body under the provisions of the NHS (Standing Advisory Committee) Order 1981. The intention is that when discussions with the Welsh Assembly Government have concluded on the future of JCVI, the 1981 Order will be revoked. The Secretary of State then intends to use his existing powers under Section 2(1)(b) of the NHS Act 2006 to reconstitute the JCVI as a non-statutory advisory body performing the same functions. The JCVI chair and members are expected to become members of the new Departmental Expert Committee when that is established.
 - NHS LA, NHS BSA and NHS BT will be subject to a further commercial review by industry experts to identify potential opportunities for greater efficiency through outsourcing, divestment and contestability and/or employee ownership, but no provision for them is made in the Health and Social Care Bill so they are not considered in this impact assessment;
 - MHRA has a clear future as an ALB, continuing to operate in the most cost effective and efficient way, but as no change is made to legislative provisions for MHRA it is not considered in this assessment.
- E6. The effect of these policies is that some ALBs will have their functions strengthened - for example, information collection, access and use, which will give scope for improving services for groups by providing better evidence of their needs and wishes. This is expected to have a positive impact on people with some of the protected characteristics – gender reassignment,

sexual orientation and religion or belief – for whom there is little evidence at present of their needs or location. It should have a positive impact on people with all kinds of disabilities and at both ends of the age spectrum and of some racial and socio-economic groups currently at high risk of adverse health issues. The changes will tend to promote equality between members of a group who share these characteristics and others who do not.

- E7. Quality standards for social care will be developed to integrate with healthcare standards, which should improve care for some highly disadvantaged groups such as people with complex needs including disabilities of different kinds, and additional characteristics such as older age, race, religion or belief, sexual orientation, gender reassignment. Standards which include integration of care on an individual needs-based assessment should enable people to receive the same level of care relevant to their needs as people without these characteristics and so promote equality.
- E8. Some of the changes brought about by the policy are not expected to have an impact on equality, for example where a function will continue to be done in the same way, such as the change in status of the AERC.
- E9. It is recognised that these policies will have an adverse impact on employees if a body that will be abolished transfers a function into another body carrying out similar functions. For instance, women make up a greater proportion of the workforce in GSCC. The Appointments Commission has a higher proportion of younger staff than in the general population. In the case of pregnant employees, they may not have a job to return to after childbirth if their employer no longer exists. These negative impacts will be mitigated by, for example:
- ALBs practising equitable transitional employment policies so that staff are considered for redundancy or redeployment without reference to any protected characteristics they have;
 - Provision of positive support tailored specifically to the circumstances and needs of staff facing redundancy under the provisions of the DH HR frameworks being developed;
 - ALBs ensuring fair treatment of all staff affected by the system change such as those under specific transition arrangements. An example of this is the oversight group set up by DH supervising the transfer of function from GSCC to HPC.
- E10. The action plan, which forms part of this EIA aims to ensure that current good equality and diversity practice is maintained when functions are transferred to be carried out by different organisations.

Out of scope

- E11. The impact of the proposals to abolish the Health Protection Agency and National Treatment Agency and to transfer their functions to the Department of Health is assessed in a separate EIA in the public health section of this document (Annex F). The impact of the proposals to abolish the Office of the Health Professions Adjudicator is in a separate impact assessment and Equality EIA⁹⁸. Finally, there are a number of proposed interventions within the ALB review that do not require primary legislation, these are therefore not covered within this document. Further information on this is found in paragraph E27 of the public bodies impact assessment.

⁹⁸ http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_122293

Relevance to Equality and Diversity

E12. The purpose of this equality impact assessment (EIA) is to inform development of this policy so that, as far as possible, it:

- (vii) Eliminates discrimination and does not generate or exacerbate inequalities in access to healthcare or health outcomes for patients and the public or employment and progression opportunities for actual/potential employees;
- (viii) Supports local efforts to reduce inequalities, promote equality and foster good relations between people from protected groups and those who are not.

E13. In carrying out this assessment, we have considered the following protected characteristics as they apply to service users and staff where relevant

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race or ethnicity
- Religion or belief
- Sex
- Sexual orientation
- Socio-economic status

E14. We have chosen to include all the relevant protected characteristics covered by the Equality Act in accordance with good practice guidance from the Equalities and Human Rights Commission (EHRC). Not all the provisions of the Equality Act are yet in force; some, such as the prohibition on age discrimination in services and public functions are still under consideration, and the public sector equality duty is due to commence in April 2011. Our consideration of these characteristics takes into account that we expect these measures to be in force when these provisions come into effect.

E15. Socio-economic status is not one of the protected characteristics that must be covered in the public sector equality duty and therefore in the EIA, but has been included for completeness of impact on current health inequalities.

E16. In addition, where a change affects employment of staff, the effect on marriage and civil partnerships is considered. Some of the provisions in the Bill give effect to policies which will have an impact on staff currently employed in existing or new bodies. The three parts of the system concerned (the Department of Health, NHS and DH's arm's length bodies) are developing Human Resources frameworks based on common principles to ensure that staff whose employment is affected by the system reconfiguration are treated fairly and equitably. These principles, which will inform and determine the frameworks' individual content, will be agreed with Trade Unions. The composition of the initial frameworks is subject to consultation with Trade Unions as will be any revisions to the frameworks.

E17. One of the principles, equality, recognises the importance of a diverse workforce and will help to ensure that no employee receives less favourable treatment on the grounds of age, disability,

gender re-assignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, gender or sexual orientation, or on the grounds of trade union membership.

The Equality Act 2010 and powers of the Secretary of State

E18. The Equality Act aims to simplify, harmonise and strengthen equality law, replacing nine major pieces of legislation and around 100 other instruments with a single Act. It received Royal Assent on 8 April 2010. The main provisions in the Act came into force in October 2010 and the single public sector equality duty will come into force in April 2011⁹⁹.

E19. The single public sector equality duty covers race, disability, and gender (existing duties), plus age, sexual orientation, religion or belief, pregnancy and maternity, and gender reassignment. These dimensions are collectively referred to as the protected characteristics. All public bodies, including those changed or set up through these provisions, must have due regard to the need to:

- eliminate unlawful discrimination, harassment, and victimisation;
- advance equality of opportunity; and
- foster good relations between those who share a relevant protected characteristic and those who do not.

E20. This general duty is underpinned by specific duties, to help public bodies meet the general duty. The Government has recently undertaken a public consultation on the specific duties.

E21. The Equality Act 2010 will ensure that all public bodies within the health service, including the NHS and the public health service, are obliged to comply with principles of equality. This will include those bodies established under the Bill, such as GP consortia, and those whose functions are changed, such as some of the arm's-length bodies (CQC, NICE and Monitor). These duties also apply to private providers in so far as they are providing NHS services, on the basis that the provision of services for the purposes of the health service is a function of a public nature. This can be brought about by measures such as the inclusion of contractual terms relating to equality in contracts with such organisations, where this is considered necessary.

Summary of evidence and stakeholder feedback

E22. This EIA relies on evidence and stakeholder feedback to:

- provide supporting evidence where actual or potential impacts on equality and human rights were identified
- assist with developing proposals for mitigating potential negative impacts
- demonstrate how proposed reforms can promote equality and human rights, where possible

E23. In order to assess the relevance of this policy to equality and diversity we have looked at the following:

- Data directly received from ALBs – this data was analysed to ascertain whether there was a disproportionate impact arising from the proposed changes on specific equality groups of staff and service users;

⁹⁹ From April 2012, the ban on age discrimination in provision of goods, facilities, services and public functions will be implemented.

- ALB equality and diversity action plans and policies were reviewed; and
 - The overall impact will be dependent on the transitional plans that are being developed for each organisation. These plans will seek to ensure the mitigation, as far as practically possible, of any equality impact from the transition of individual organisations (see details below for each ALB). The abolition of or significant change to ALBs will have an impact on their staff, although this will not necessarily have a disproportionate impact on different staff groups (see details below for each staff group).
- E24. The proposals made in the ALB Review Report are mostly related to organisational restructuring including transfer of functions to other bodies. This covers:
- Transferring the functions from one organisation or location to another
 - Abolishing a body and making the staff redundant
 - Changing the funding model
 - Changing the legal status and altering some functions of a body
- E25. There is limited evidence on the impact of organisational change, such as those proposed in the ALB Review Report, on health inequalities or the promotion of equality. Therefore, much of the evidence included within this document is drawn from ‘grey’ literature or hypothesis. Reports on the impact of recession and its associated effects (e.g. redundancies) on different equality groups help to understand some of the more indirect consequences of change programmes. The variety of available evidence includes case law from employment tribunals resulting from unfair dismissal of staff following organisational restructure. This case law highlights potential difficulties to be considered when carrying out organisational restructure and ‘lessons learnt’ from previous experiences, and emphasises the need for thorough EIAs to be undertaken. Some impacts on staff and service users of these changes will be immediately apparent, while some will be less direct
- E26. An advice note for public authorities issued by the Equality and Human Rights Commission describes how decisions such as efficiency drives, budget cuts and relocations can have a disproportionate impact on certain groups of people. Press reports are cited to suggest that women are more likely to be affected by redundancies, for example, as companies revise flexible working policies.
- E27. Evidence specific to ALBs, including equality and diversity schemes, transition plans for the proposed changes and data on the ALB staff and service users, broken down by equality strands are all useful in determining potential positive or negative impacts of the proposed changes. This ALB-specific evidence is considered in the following paragraphs.
- E28. The changes will have an impact on staff currently employed in existing or new bodies. The three organisations concerned (the Department of Health, NHS and DH’s arm’s length bodies) are developing Human Resources frameworks based on common principles to ensure that staff whose employment is affected by the system reconfiguration are treated fairly and equitably. These principles, which will inform and determine the frameworks’ individual content, will be agreed with Trade Unions. The composition of the initial frameworks is subject to consultation with Trade Unions as will be any revisions to the frameworks.
- E29. For socio-economic status and human rights: the needs of hard to reach groups have been well documented – see Burnett, A and Peel, M (2001): *Asylum seekers and refugees in Britain: Health needs of asylum seekers and refugees* (British Medical Journal, 2001, Vol.322, pp.544-547).

NICE's *Management of pregnancy for women with complex social needs*¹⁰⁰ has a specific chapter on asylum seekers and refugees requiring antenatal care. For race and age (young people): children in care experience inequalities in outcomes and access to services. NICE's *Promoting the quality of life of looked after young people and children*¹⁰¹ makes, for example, specific recommendations regarding BME children in care with mental health illness accessing child and adolescent mental health services (CAMHS). For age (older people) and disability: people aged 65 and upwards are likely to see an increase in ill health and disability as they grow older (Compendium of Clinical and Health Indicators / Clinical and Health Outcomes Knowledge Base¹⁰²). This also has social, emotional and economic implications for their families who then become carers. NICE has issued the following guidance: "Dementia: Supporting people with dementia and their carers in health and social care"¹⁰³. General information on NICE's equality scheme is also available¹⁰⁴. The change in NICE's status is not anticipated to make any difference to its current impact, so it is not expected to have any positive or negative impact.

Discussion of potential impacts

E30. This section covers the ALBs that are altered by primary legislation in the Health and Social Care Bill, and talks about the potential impacts across the equality strands. This follows the same order as the impact assessment. Within each ALB, the impact upon service users and staff is considered explicitly, as well as other important stakeholders where relevant. Some examples of the work undertaken around equalities is also included.

National Institute for Health and Clinical Excellence (NICE)

E31. NICE will be abolished as a special health authority and will be re-established as a body corporate to take on similar functions. Following the proposed changes the new body will be subject to equalities duties, in the way it treats its staff and, when commissioned by the Board or Secretary of State (SofS) to prepare a Quality Standard, and under regulations as to the additional functions it will have. NICE will be obliged to have regard to the NHS Constitution. This contains a right not to be unlawfully discriminated against in the provision of NHS services based on the protected characteristics.

Impact on service users

E32. The special health authority (SpHA) NICE currently carries out an EIA on each of its quality standards. This includes consideration of all the equality strands. There is no reason to think that the changes to legislation made as a result of this policy will change this position.

Impact on staff

E33. There will be an expansion of the functions of NICE as re-established. There is not anticipated to be any differential impact across equality strands of staff who will all transfer to the re-established body

¹⁰⁰ <http://guidance.nice.org.uk/CG110>

¹⁰¹ <http://guidance.nice.org.uk/PH28>

¹⁰² www.nchod.nhs.uk

¹⁰³ <http://www.nice.org.uk/nicemedia/live/10998/30321/30321.pdf>

¹⁰⁴ <http://www.nice.org.uk/aboutnice/howwework/niceequalityscheme.jsp>

Evidence of good practice

E34. NICE the SpHA has submitted its own EIA covering its customers and staff. NICE considers the equality impact of its guidance programmes as a whole and individual product development. It is anticipated that the body as re-established will carry out its new functions using similar procedures. Therefore this should mitigate against any negative impact on equality whichever protected group it might relate to. NICE also consults widely and makes use of diversity networks and these practices are expected to be adopted by the body as re-established when carrying out functions similar to those currently conferred on the body as a Special Health Authority.

Care Quality Commission (CQC)

E35. Changes to requirements for approval of treatment by Second Opinion Appointed Doctors; Move some National Information Governance Board (NIGB) functions to CQC; Responsibility for overseeing the quality of NHS commissioning will belong to the NHS Commissioning Board, so the CQC will no longer undertake periodic review of NHS commissioners or NHS providers.

E36. The CQC will continue to be subject to equalities duties, following the proposed changes.

Second Opinion Appointed Doctors (SOADS) – Impact on service users

E37. The changes in relation to SOADs will mean that it will generally no longer be necessary for patients on supervised community treatment (SCT) under the Mental Health Act 1983 to have treatment to which they consent approved by a SOAD. SOADs are responsible for providing a second opinion for those held under the Mental Health Act who wish to undergo community treatment. Their function will be reduced only to provide an opinion where the patient does not give consent. This could be of particular relevance to groups disproportionately represented within the population of those with mental health problems. 'Count Me In 2009', the fifth national census of in-patients in mental health and learning disability services found that 22% were from minority ethnic groups – double the percentage within the national population at the 2001 Census, although we know that there have been demographic changes since that time. There will be a benefit to those SCT patients who find it inconvenient (or even offensive) to have to be examined by a SOAD before they can be given treatment to which they are consenting. Such an examination will no longer be necessary. However, some patients may feel it is a disadvantage that their treatment will no longer automatically be scrutinised by an independent SOAD in the way it should be now.

E38. There is no reason to think that the change will impact differentially on different SCT patients by reason of disability, gender, gender reassignment, marriage and civil partnership, race, religion or belief, sexual orientation or socio-economic status. However, the Government acknowledges that the characteristics of SCT patients as a whole do not reflect those of the population of England and Wales. For example, men are more likely to be SCT patients than women (at 31 March 2010, in England, around 66% of SCT patients were men¹⁰⁵). There is also evidence that people in the White British group are less likely on average to be discharged from detention onto SCT, whereas that is more likely than average to happen for those in the Indian, Bangladeshi, Black

¹⁰⁵ Source: In-patients informally detained in hospitals under the Mental Health Act 1983 and patients subject to supervised community treatment, annual figures, England, 2009/10 (Information Centre, October 2010), Reference Table 7

Caribbean and Other Black groups, in some cases significantly so¹⁰⁶. Moreover, the mental disorder for which SCT patients are being treated will, in many cases, itself constitute a disability.

SOADS - Impact on Staff

E39. A consequential effect of the amendment will be to reduce (in theory) the amount of work, and therefore payment, that would otherwise be available to SOADs themselves. However, given general trends in demands for SOADs (who must also approve treatment for many detained patients), this is not thought likely in practice to lead to any SOADs losing their role, or being offered significantly less work than now.

E40. There are around 120 SOADs, mostly part-time or retired doctors, so the changes are likely to disproportionately impact part-time and older SOADs. However, the CQC does intend to increase the level of SOAD work in other areas so the impact should be balanced, as workload is likely to maintain its current level. The effect on CQC staff should also be neutral since the impact on workload should affect SOADs only.

National Information Governance Board (NIGB)

E41. Policy proposal: move some of the NIGB functions under CQC initially to be overseen by a statutory committee.

Impact on service users

E42. For NIGB, the direct service users are the Secretary of State for Health and NHS and social care organisations. NIGB monitors and provides guidance to NHS and social care organisations and advises the Secretary of State on matters relating to information governance, including being consulted on control of patient information regulations. It is anticipated that following the transfer of NIGB functions to CQC, the monitoring function will be delivered in largely the same way and there is, therefore, unlikely to be an impact on NHS and social care organisations. As CQC in future will be consulted on control of patient information regulations and must keep the relevant organisations, Monitor and NHS Commissioning Board informed of the performance of organisations in relation to information governance, the Government should similarly not be adversely affected by CQC carrying out these NIGB functions.

E43. As the CQC currently has robust equality policies in place for both service users and staff¹⁰⁷, we can be confident that moving NIGB functions under the governance of the CQC will mean that existing equality policies will remain, or even be improved, through exposure to best practice. The association of NIGB functions with the CQC is expected to strengthen information governance standards across NHS and social care organisations by explicit links to registration requirements and licensing arrangements. The requirement for CQC to maintain a committee until 2015 will ensure that its knowledge and expertise are transferred and embedded within the CQC's business as usual working processes

¹⁰⁶ Count Me In 2009 (Care Quality Commission, January 2010) pages 23 &24.

¹⁰⁷ There is a toolkit available on the CQC website to aid completion of the Equality and Human Rights Assessments. In addition to this there are examples of current EIAs and an equality and Human Rights scheme, available in a number of formats. Accessed at: <http://www.cqc.org.uk/aboutcqc/howwedoit/promotingequalityandhumanrights.cfm>

Impact on Staff

E44. NIGB will transfer its statutory functions to the CQC from April 2013. Existing CQC staff should be unaffected by the change. The implications for the 10 staff currently assigned by the Department of Health to support the NIGB will be worked through during 2011/12 and 2012/13 and staff will be fully consulted and supported in whatever outcomes are agreed. As with all other Department of Health changes the process will be carried out with due regard to all the equality strands. Legal provision will be made to ensure staff are treated fairly.

Periodic Review of providers

E45. We expect that the Periodic Review function of NHS commissioners will be delivered in a similar way under the NHS Commissioning Board. We are working to determine who (if anyone) should carry out periodic review of providers in the future. If it is decided in future to cease the function of periodic review, a full EIA of the policy will be carried out at that time.

Impact on Staff

E46. There are currently no staff dealing with the Periodic Review function at the CQC, therefore we expect no impact on staff in moving this function in relation to NHS commissioners to the NHS Commissioning Board.

Council for Healthcare Regulatory Excellence (CHRE)

E47. Policy proposal: To become self-funded by levying a statutory charge on all existing regulators. The CHRE will still be subject to equalities duties, following the proposed changes.

Impact on service users

E48. The term 'service user' here covers the direct users (the registered professionals who are the registrants of the existing regulators) and the indirect users (patients and the public). The health professions regulators do not currently collect comprehensive information on registrants by equality strand. Some regulators (the General Medical Council and the General Dental Council) have recently introduced plans to collect equality data¹⁰⁸.

E49. CHRE will be funded by a compulsory levy on the regulators, and regulators will be free to choose the extent to which they pass on the cost of the levy to their registrants. It is estimated that the costs involved would mean that each registrant might pay around an extra £2 on their current registration fee. In our view, this increase is too small to have any significant impact on any of the equality strands.

E50. CHRE will have an expanded remit in quality assuring the professional regulation of social workers in England. CHRE will have new powers to refer a social worker final fitness to practise decision to court when it believes the decision is too lenient. This means that final fitness to practise decisions about social workers in England will be subject to a greater level of scrutiny, and some decisions may be reversed by the court. However, since the number of referrals by CHRE is very low (two in 2009/10), we do not anticipate that any of the equality groups will be

¹⁰⁸ GDC Annual report 2009, GMC Council minutes 2009

significantly affected by the change. For a similar reason, those using services provided by social workers are not assumed to be significantly affected.

E51. CHRE will also be enabled to accredit voluntary registers of unregulated health professionals and health care workers in the UK and social care workers in England. It is not yet known which groups of workers will apply to the CHRE for accreditation of their register, and so no assessment of equality impact can be made until the groups affected are known.

E52. CHRE will also have new powers to assist the Privy Council in carrying out its appointment functions to the regulatory bodies and the CHRE itself, and to assist the Devolved Administrations in carrying out their functions of appointing a non-executive member to the CHRE. It will continue to observe its equality duties as a public body.

Impact on staff

E53. The functions carried out by staff will be expanding to include oversight of social workers' regulation and accreditation of voluntary registers of unregulated health professionals and health care workers and social care workers in England. We do not anticipate any differential impact across different equality strands of staff.

Evidence of good practice

E54. The recruitment of staff at the CHRE is undertaken with a commitment that "CHRE will not discriminate directly or indirectly when advertising a post".

E55. Examples of the work undertaken by the CHRE include:

- Working with the regulators on improving their commitment to equalities
- Leading work with regulators on how to investigate allegations of racism
- Investigated allegations of racism at one regulator on behalf of the Secretary of State.
- Developing policy advice and the development of practice changes on health conditions in response to the Disability Rights Commission
- Ensuring that the regulators handle all complaints with due regard to equality issues
- Ensuring that patients and the public are properly recognised through its role in patient advocacy

E56. In the absence of the CHRE this work would not have been undertaken. CHRE's functions will be expanding significantly. We expect the CHRE's current functions to continue to be carried out in the same way and we also expect that its new functions will be carried out with the same regard to equality and diversity. Therefore, if there is any impact upon equality resulting from this policy change it is likely to be positive.

General Social Care Council (GSCC)

E57. Policy proposal: Transfer the role of the regulation of social workers in England to the Health Professions Council (HPC) and abolish GSCC.

E58. This proposal is for a change only in the mechanism of how social workers in England are regulated. It is being delivered by transferring the function from one body that is subject to, and complies with, the statutory equality duties to another such body. GSCC is an ENDPB, and the

HPC, although not in the ALB sector, is recognised as a public body and both organisations are bound by requirements relevant to the equality and diversity agenda. During the transition period we expect the GSCC and HPC will work in partnership to achieve their equality duties and ensure that appropriate action is taken to prevent or mitigate any adverse impact on any of the equality strands.

Impact on service users

- E59. The term service users here describes the direct users (the social worker workforce, and approved mental health professionals (AMHPs) and the indirect users (patients and the public). The impacts are expected to occur initially on social workers who are currently registered with GSCC, but ultimately on service users who would be affected by poor care delivered by social workers with vulnerable adults and children disproportionately affected.
- E60. From figures provided by the GSCC, social workers in England are broadly representative of the general population in terms of age, ethnicity and disability, and while a majority of social workers (77%) are female, the impact of the changes will not differ between men and women in general. There is no reason to think that the change in regulatory mechanism would have any disproportionate impact on social workers as a whole due to religion or belief, or sexual orientation.
- E61. Users of social work services may be drawn disproportionately from some equality groups, particularly older and younger people and those with disabilities of all kinds. The social care provided needs to reflect lifestyle, characteristics and beliefs of those receiving the services and people with multiple protected characteristics could be doubly affected. However, the users of these services are unlikely to be affected negatively as the regulatory functions in relation to social workers in England will continue. Service users are in fact likely to benefit from the transfer; for instance, the HPC's fitness to practise system is expected to deal more effectively with competence issues than the GSCC's current conduct system.
- E62. The evidence to support this is informed by issues relevant to GSCC's ability to regulate social workers efficiently. In June 2009, the GSCC notified the DH that a backlog of conduct referrals had been identified. Subsequent events and an independent report by the Council for Healthcare Regulatory Excellence (CHRE)¹⁰⁹ identified significant failings in the conduct function of the organisation. Under its new leadership team the GSCC has made progress in developing the organisation in response to the CHRE Report. However, its costs have significantly increased as a result of the improvements made and it would be challenging for the Department or for individual social workers to meet these costs. We believe the transfer is the most cost-effective means to effective and sustainable regulation of social workers. More detail is available in the report itself.
- E63. The Government is confident that the HPC is well placed to take on the regulation of social workers in England and that this option will be best in the long-term for the public, social workers and their employers. HPC is an experienced regulator with a proven track record of providing effective, safe and value for money regulation for 15 professions. In its Performance Review Report 2009/10¹¹⁰ the CHRE described the HPC as a 'well-organised, efficient and cost-effective regulator' which maintained a good performance as it assumed responsibility for further

¹⁰⁹ <http://www.chre.org.uk/publications/#folder10>

¹¹⁰ http://www.chre.org.uk/_img/pics/library/100806_Performance_review_report_2009-10_tagged_1.pdf

professions. It is anticipated that the change in regulatory mechanism should have no significant impact on any of the equality strands with respect to the social work workforce in England, since the regulatory mechanism will continue in another body that is subject to, and complies with, the statutory equality duties.

- E64. Social workers and social work students pay a registration fee to GSCC. Figures from GSCC indicate that if they were to become an independent self funding body their fees would rise. The transfer of the function of social work regulation to HPC will result in a rise in fees for social workers, expected to be in line with fees charged to other professions regulated by HPC. All social workers would be charged the same fee, irrespective of earnings. There is a higher proportion of women in the social worker workforce than in the general population, so this equality strand would be more affected. However, given the earnings of social workers are broadly comparable to other professions regulated by HPC, the costs of regulation would not be disproportionate compared to other professions in a similar socio-economic position.
- E65. The HPC does not currently regulate students. Rather it requires, as part of its approval process, Higher Education Institutions delivering pre-registration courses to operate fitness to practise schemes for students. Decisions about the model to apply to social work students have yet to be taken and therefore the cost implications and any impact on any of the equality strands are as yet unclear.
- E66. The changes in relation to the approval of courses for AMHPs in England (the vast majority of whom are social workers) or would-be AMHPs are unlikely to have any disproportionate impacts on any of the equality strands.

Impact on staff

- E67. The functions relevant to the regulation of social workers in England are transferring from GSCC to HPC. The implications for GSCC staff are being worked through and staff will be fully consulted and supported in whatever outcomes are agreed. It is intended that this process will be carried out with due regard to all the equality strands. Any necessary legal provision will be made to ensure staff are treated fairly.
- E68. The current GSCC workforce consists of around 250 staff, of whom about 50 are non-permanent. As both GSCC and HPC have statutory equality duties and because they are committed to the delivery of the equality and diversity agenda the Department can be confident that the processes they apply relevant to the transfer process will not be discriminatory, although DH will keep this under review.
- E69. The staff make-up of the GSCC is broadly in line with the national population, with the exception of having a higher proportion of female staff (78%). The staff within GSCC will be given necessary training and information to help apply for new jobs.

Evidence of good practice

- E70. The HPC demonstrates, in its own equality and diversity scheme¹¹¹, robust, equitable processes that will be adopted in relation to the regulation of social workers. For example the HPC describes individual equality policies for six equality strands (disability, age, race, gender, sexual

¹¹¹ <http://www.hpc-uk.org/aboutus/aimsandvision/equality/>

orientation, religion or belief), ensuring that their practices are representative of their own workforce and the workforce they regulate and adequately consult with relevant equality groups.

Alcohol Education and Research Council (AERC)

E71. Policy proposal – Facilitate the closure of the AERC as an ALB. The AERC intends to set up a new charitable body to continue the AERC's existing function of administering a fund to carry out research into alcohol-related harm. The legislation will abolish the Council and remove references to the AERC from other legislation.

Impact on service users

E72. The anticipated impact from closing the AERC is minimal.

Impact on staff

E73. The AERC intends to transfer all of its staff and council members to the new charitable body with no change of terms and conditions planned. There is no equality impact anticipated.

Health and Social Care Information Centre (IC)

E74. Policy proposal: Abolish the SpHA the Health and Social Care Information Centre, and establish a body corporate with the same name to take on similar functions with expansion of responsibilities to eradicate data collection duplication and to become the national repository for health and adult social care data.

Impact on service users

E75. Organisations that are users of the IC's services are expected to benefit from a uniform approach to central data collection, increasing choice and detail of data. The NHS Commissioning Board will decide what NHS information should be collected to meet the needs of patients and the public, and enable them to exercise choice. The Secretary of State will decide similarly in respect of what public health and social care data should be collected centrally. As bodies subject to the public sector equality duties, the Board and the Secretary of State will be required to take steps to advance equalities when deciding what IC should collect.

E76. The IC will have to ensure that data that it collects is collected in the most efficient and equitable way, giving due consideration to relevant equality groups to ensure fairness and non-discrimination. The IC will have a duty to minimise central data collection burden, but should also consider where there would be impact on equality, eg by ensuring that central data collections are not stopped arbitrarily where this would have an adverse effect on equality. The IC will be obliged to have regard to the NHS Constitution, which gives service users the right not to be unlawfully discriminated against in respect of the protected characteristics.

E77. The IC's current website allows users to change the size and colour of the font, navigate using a keyboard and change the language. The new IC as re-established is expected to provide similar services and improved website functionality. The IC's new functions will involve additional data collections, and opportunity to publish more data for analysis by reference to specific groups, eg on equality of access to services.

- E78. However there will be a need to consider how to allow participation by IC users who do not or cannot use computers, since otherwise there will be a negative impact on these groups. These include some people with disabilities, some older people, some women, asylum seekers, refugees, travellers and some socio-economic groups,
- E79. The role of the IC is also covered in *Liberating the NHS: An Information Strategy* consultation, published in October 2010. A further impact assessment and equality impact assessment will be published to accompany the Government's response to this consultation.

Impact on staff

- E80. There will be no change in the location of staff. We expect there to be little impact on staff at the IC as, while the remit of the functions in the body will increase, there should not be any disproportionate impact on specific equality groups. All staff of the current SpHA are likely to transfer on substantially the same terms and conditions, and the same working policies are expected to be applied by the new body notwithstanding the change to the functions and activities of the new body. The role of the IC is also covered in *Liberating the NHS: An Information Strategy* consultation, published in October 2010. A further impact assessment and equality impact assessment will be published to accompany the Government's response to this consultation
- E81. The new body is expected to promote equality by applying the same or a similar policy to the IC's current Equality and Diversity policy, Single Equality Scheme and action plan. The change is not expected to affect equalities because the status quo will be preserved.

Appointments Commission (AC)

- E82. Policy proposal – Abolish the AC from 2012. The majority of the Appointments Commission's appointments will cease following wider restructuring, and responsibility for making remaining appointments will return to the Secretary of State for Health and will be discharged by officials of DH. This is in line with other Government Departments. The intention is that Privy Council will be able to make arrangements with any other body for it to assist it in making appointments.

Impact on service users

- E83. AC has ensured that public appointments are widely advertised in specialist media to ensure wide access, and have carried out appointments on merit regardless of background of applicants. AC has also monitored results of appointment exercises to analyse breadth of applications, recruitment and take-up of posts to enable compensatory action to be taken if particular groups are found to be less well represented in these exercises than they might be expected to be.
- E84. At present, the AC takes full account of equalities when making public appointments. It is therefore necessary that those making public appointments in the future apply the same good practice as AC. There is no reason to believe that the changes to the appointments process will lead to certain groups being disadvantaged, as DH and the Privy Council are public bodies and are bound by the public sector equality duty in the Equality Act 2010 and by relevant Cabinet Office guidance (*Making and Managing Public Appointments – A Guide for Departments*). DH will work with Cabinet Office and Government Equalities Office (GEO) to ensure that it continues to apply best practice in terms of attracting women, black, minority and ethnic groups (BME) and disabled people to apply for posts and that selection is based on merit. There is therefore no

reason to assume that the abolition of the AC will result in any differential impact on service users according to their background.

Impact on staff

- E85. Since the AC is to be abolished, most staff are likely to face redundancy. Provision will be made in the Bill to enable some staff of AC to transfer. However, only a few are expected to be able to benefit. The AC's current workforce has a majority of female staff (80%) and a higher proportion of people in the 26-30 age group than in the general population. (20% against 10%).
- E86. AC is preparing a full programme of communication and support for staff, including training in preparing for outsourcing, redundancy and job applications. This will be targeted to provide advice tailored to groups most affected.

National Patient Safety Agency (NPSA)

- E87. Policy proposal: Move some of the Patient Safety Division (PSD) functions of the NPSA to the NHS Commissioning Board.
- E88. As only the functions relating to the PSD will require primary legislation in the Health and Social Care Bill, the analysis below considers only this aspect of policy. All other changes, relating to the National Clinical Assessment Authority (NCAS), the National Research and Ethics Service (NRES) and the confidential patient enquiries will be dealt with separately.

Impact on service users

- E89. Users of services provided by the PSD include healthcare providers, patients and the public. The aim of transferring the main patient safety functions from the NPSA to the NHS Commissioning Board is to provide an opportunity for embedding patient safety principles into the commissioning of services generally, therefore improving the focus on patient safety. Because of this, it is hoped that any impact on services users with protected characteristics as compared with others is likely to be neutral or even positive. The Department wants patient safety to have a higher profile. Safety and quality improvement will be at the centre rather than at arms length as it currently is. It will be for the newly created NHS Commissioning Board to decide how exactly it wishes to continue the work of the PSD, but it is likely that this will include continuing to secure the core functions of the PSD, including the delivery of the National Reporting and Learning Service.
- E90. Errors in health care are limited to those people receiving health care, and older people use health services more than any other demographic. There is some evidence that older people are more at risk from certain adverse events (Thornlow, 2009). Those with disabilities also use health services proportionally more than some other demographic groups. This means there is the potential for those with disabilities to be at increased risk from patient safety errors. The NPSA reported in 2004 that people with learning disabilities are at greater risk from some types of patient safety incident (NPSA, 2004). It follows therefore that any improvement in patient safety may decrease any unequal impact of safety incidents on older people or those with disabilities, therefore improving equality. The converse is also true in that any deterioration of patient safety generally may have a disproportionate impact on older people and those with disabilities.
- E91. There is conflicting evidence on the link between safety and ethnicity. Some research suggests that as a whole, the likelihood of experiencing a patient safety incident does not consistently vary

with racial background (Shimada et al 2008). Other research does argue there is a link, but indicates it is due to factors that operate in the US health system as opposed to the UK NHS (for example issues with access to health care and disparities in the quality of health care provider accessible to different ethnic groups) (Coffey et al 2005). Even in studies that suggest a negative safety impact due to ethnic minority, only some types of safety events appear to impact disproportionately on ethnic minorities. Other safety incidents disproportionately affect Caucasian patients, further suggesting the causes for differential impacts are multi-factorial and specific to the type of event, rather than being consistent for minority groups across all safety events. On this basis, it is very difficult to make an overall assessment for this policy area on ethnicity and equality. Patient safety policy is aimed at reducing errors in health care. If errors disproportionately impact on one or more ethnic groups, then it follows that this work to improve safety should reduce those inequalities. Conversely, any negative impact on patient safety policy may increase inequalities. However, in the absence of evidence showing errors disproportionately affecting certain ethnic minorities, there is no evidence to suggest that this policy disproportionately assists one ethnic group over another.

- E92. The evidence on the impact of socio-economic grouping on the rate of errors in health care is similar in many ways to that on ethnicity. Research suggests for some types of error, people on lower incomes are at greater risk. However, the converse is also true in that for some types of error, those with lower incomes are at less risk (Coffey et al 2005). This research is based on the experience in the USA where socio-economic background has a greater impact on access to healthcare due to the specifics of the US healthcare system, therefore it is debatable whether such research is applicable to the UK. At the same time, the research states that it is not possible to make definitive statements about the impact of socio-economic background on error rate in general, only for particular types of error. So again, conclusions are difficult to draw.
- E93. There is no evidence to demonstrate any unequal impact, positive or negative, of patient safety incidents in general on different genders, religions or sexual orientations

Impact on staff

- E94. Some of the staff currently at the PSD will be made redundant since only part of the patient safety function will be transferring to the Commissioning Board. The Board will be set up as a Special Health Authority (SpHA) initially so if any transfer of staff occurs while the Board is a SpHA then staff should not incur any changes to terms and conditions as the staff of the NPSA are currently employed by a SpHA. The same terms and conditions are expected to apply when the provisions in the Bill in respect of the establishment of the Board and transfer of staff to it are commenced.
- E95. Based on data collected from the NPSA, the workforce is broadly in line with the general population with the exception of having a higher proportion of women (70%). The NPSA are working with their Board and the Department of Health to ensure a robust transition plan is put in place to help protect staff .NPSA have offered CV and interview training to staff to enable them to apply for new jobs. These could be tailored to meet the needs of women who may be disproportionately affected. Staff in the NPSA have been subject to a full consultation on the proposals from 2 December.
- E96. As the NPSA is to be abolished, following the transfer of the PSD to the Board, it is vital that these good equality practices are maintained. The NHS Commissioning Board will have its own policies relating to equality and diversity, and therefore there is assumed not to be a negative

impact on staff with protected characteristic transferring to the Board. The Commissioning Board will need to ensure that it (and, in particular, its patient safety sub-committee) have equality and diversity policies which are at least as good as the NPSA's ones to mitigate any potential negative effect of the transfer from NPSA of women and other staff with protected characteristic.

NHS Institute for Innovation and Improvement (NHSIII)

E97. Policy proposal: Move Leadership of Quality Improvement function to the NHS Commissioning Board. The rest of the divisions of the NHSIII are to be reviewed to explore commercial viability.

Impact on service users

E98. The direct users of the NHSIII are clinicians and managers providing healthcare services. The indirect users are the patients and the public being treated by providers who follow the NHSIII advice.

E99. The expectation is that the leadership function will be delivered to the end user in a broadly similar way to the present. We do not anticipate any disproportionate impact from this change.

E100. To ensure innovation continues to be promoted and supported across the NHS innovation needs to be a system wide undertaking, and this guiding principle drives the shift of roles and responsibilities. The NHS Commissioning Board will take a lead role in promoting commissioning for innovation. This will affect all clinicians and managers involved in leading innovation equally so there is no expected impact on equality.

E101. Innovation has always been an activity of providers of services and will continue to be so. With greater decentralisation and more freedom for NHS Trusts they will demonstrate locally to patients and stakeholders what they have done to promote innovation and accelerate the adoption of best practice. This leadership of innovation is expected to affect all services users equally so there is no anticipated impact on equality.

E102. During the transition period the Department will work with the NHSIII to ensure that if any adverse impact is identified, although none is anticipated, it will be considered and action taken to minimise or eliminate it.

Impact on staff

E103. Following collection of staff data, broken down by key equality groups, analysis highlighted a number of groups that may be adversely affected by the proposals. Disabled staff members could be disproportionately affected as 12% of the total NHSIII workforce has a disability¹¹², compared with 4% of the population. Female members of staff make up 73% of the total NHSIII staff, whereas 51% of the population of England are female. The NHSIII also has a high number of staff in the 31-40 years age bracket (32%, compared with 23% of the working age population in England). These groups could be affected disproportionately by the changes. There will be a change programme and HR framework in place to ensure all employees are supported, treated fairly and in line with employment law.

¹¹² The definition of disability here includes health problems and long standing illness.

E104. From the early stages of the ALB review, the NHSIII have actively communicated with all staff through briefings forums and a regular e-bulletin, providing updates on progress. DH will work with NHSIII to ensure that their preparations for moving to the new system will be tailored to reflect the needs of all staff.

Evidence of good practice

E105. Along with other public sector organisations (including the Department of Health) the NHSIII has developed a Equality and Diversity Action plan that describes the Single Equality Scheme, which was developed to address obligations and duties relating to race, disability and gender diversity, along with other diversity strands including religion and age.

Joint Committee for Vaccination and Immunisation (JCVI)

E106. Policy proposal: Abolish the JCVI and reconstitute it as a non-statutory advisory body performing the same functions.

E107. Section 250 of the NHS Act (2006) will be repealed in the Health and Social Care Bill. This will effectively remove the power from the Secretary of State to establish standing advisory committees in statute. One consequence of this would be the abolition of the Joint Committee on Vaccination and Immunisation (JCVI). However, the Bill includes a *saving provision* which maintains JCVI as a statutory body under the provisions of the NHS (Standing Advisory Committee) Order 1981. The intention is that when discussions on the future of JCVI have been concluded, the 1981 Order will be revoked. The Secretary of State then intends to use his existing powers under Section 2(1)(b) of the NHS Act 2006 to reconstitute the JCVI as a non-statutory advisory body performing similar functions. .

E108. The JCVI chair and members are expected to become members of the new Departmental Expert Committee when that is established. Therefore, we do not expect any impact on people who share a protected characteristic of this change. Its functions will also remain substantially the same, including its advisory role to SofS. Its work however will be more closely aligned with the public health functions of the Department. A further assessment of the impact of this change will be made when JCVI is reconstituted but given the intention for this committee to continue as before we do not, at this stage, consider there is likely to be any negative impact.

E109. While the repeal of section 250 itself will remove from SofS the power to establish advisory committees under this provision, section 2(1)(b) of the NHS Act (2006) provides a power for SofS to set up a committee or committees for the purpose of discharging his duties under that Act. JCVI is the only existing advisory committee to be set up under section 250. In the light of the principles established by the Arm's Length Bodies Review, including reducing the number of ALBs and making the remaining bodies more efficient, the Department does not consider that retaining a specific power to establish further advisory bodies under statutory provisions remains necessary or appropriate.

E110. As JCVI is the only existing body to have been set up under this provision, and the impact of that change is discussed above, no further consideration is made in the impact assessment.

Action Plan

DH actions

- DH will work with ALBs to help them to achieve robust transitional plans and will ensure that they fully consider equality issues during this process. In particular DH will set timescales for ALBs and bodies receiving ALB functions to agree implementation plans which cover transfer of function, process, staff and where appropriate funding and assets. These plans should reflect an understanding of the impact on groups of service users and staff with different protected characteristics, and should demonstrate how adverse impacts will be mitigated.
- Collect feedback from key staff and stakeholder consultation events to ensure that staff and stakeholders are being consulted in a way that is equitable and appropriate.

ALB action

- In addition existing ALBs have already or will carry out equality impact assessments to consider the impact on age and socio-economic disadvantage. New bodies being formed or reformed under this Bill will also be expected as public bodies to carry out equality impact assessments.
- Collect feedback from key staff and stakeholder consultation events to ensure that staff and stakeholders are being consulted in a way that is equitable and appropriate.
- Collect business data through the Information Centre and feedback from patients and user groups and affected groups in the population to monitor and evaluate the effect of these policies as they are implemented.

Action by DH ALB team, ALBs and other partners related to ALBs includes:

AERC

- No additional equality action required.

AC

- Ensure the good diversity and equality policy introduced by the AC is continued in the new system, by ensuring that those making public appointments in the future develop and use similar equality expertise. DH will work with Cabinet Office and GEO to ensure that we continue to apply best practice in terms of attracting women, BME and disabled people to apply for posts and that selection is based on merit.

GSCC

- For staff that transfer, the GSCC will ensure that the final outcome does not impact negatively on any equality strand. For others, it will ensure that preparation for redundancy is carried out equitably. This will be supported by the Social Work Regulation Oversight Group which is committed to ensuring that people affected by the transfer are treated fairly and with respect.
- The DH-led oversight group will ensure that HPC as receiving body works with GSCC to ensure smooth transfer of the social worker regulation function in England so that there is no adverse impact on any of the equality strands with respect to users of social care and social workers in England.

NICE

- For staff that transfer to the new body, expected to be all staff, NICE will ensure that the final outcome does not impact negatively on any equality strand.

IC

- For staff that transfer to the new body IC will ensure that the final outcome does not impact negatively on any equality strand.
- DH will monitor the new body to ensure that it carries out its new functions equitably.

NPSA

- DH will monitor the development of the patient safety function by the NHS Commissioning Board and evaluate its impact on groups of patients within the population who share a protected characteristic, particularly those at greater risk of adverse incidents due to their sharing protected characteristics.
- NPSA will complete data on number of disabled staff at the PSD to assess and mitigate any disproportionate impact on them as a result of staff transfer.
- DH and NPSA will consider socio-economic impacts on staff if they move outside of London, including those who transfer to the NHS Commissioning Board.

NHSIII

- Monitor and assess equality impact of transfer and changes of innovation functions from ALB to NHS Commissioning Board to evaluate any impact on patients likely to suffer disadvantage due to the protected characteristics, although none is anticipated.

CQC

- Monitor the effect of the changes on service users, particularly those with mental health problems.
- Complete data collection and analysis on the equality strands for SOADs in conjunction with CQC.

NIGB

- DH will monitor the transfer of the 10 staff engaged on NIGB work into CQC to ensure that they are fairly treated.

General actions for all policy proposals

- Collect feedback from key staff and stakeholder consultation events to ensure that staff and stakeholders are being consulted in a way that is equitable and appropriate.
- Find out when existing, recipient and new ALBs will be producing their EIAs and equality schemes.
- Collect business data through the Information Centre and feedback from patients and user groups and affected groups in the population to monitor and evaluate the effect of these policies as they are implemented.

Table 1 – Potential Impacts on Protected Groups

E111. This table demonstrates potential impacts which have been identified on each of the protected characteristics as a result of each of the changes to the ALBs which are considered in this EIA. Where the table does not identify a potential impact of the policy in relation to a particular ALB (either positive or negative) on one of the protected characteristics (i.e. age, disability including carers of disabled people), race, gender, gender reassignment, sexual orientation, marriage and civil partnership, and religion or belief), the Department has come to the view that the policy in relation to that particular ALB does not have a positive or negative impact on that protected characteristic.

Protected characteristic	Potential impact	Mitigation/Opportunities for promotion of equality
Race	Removal of public appointments function from the Appointments Commission could disproportionately negatively affect people from BME backgrounds seeking public appointment on merit	DH intends to support CO & GEO [DN: and Privy Council/MoJ and CHRE in relation to CHRE appointments? You may need to speak with those responsible for policy on CHRE about appointments in future t CHRE.] in ensuring a comprehensive programme is in place to attract people into applying for posts. DH intends to continue with AC's 'best practice' regarding the handling of the Recruitment & Selection process.
	Transfer of innovation and improvement initiatives to the NHS Commissioning Board could adversely affect people of minority ethnic groups if there is a diminution of these initiatives as a result of the transfer	NHS Commissioning Board and NHS III until abolition to continue to promote leadership of innovation particularly to address issues of current inequality.
	Quality standards and guidance developed by NICE [that include recommendations in relation to social care services] could positively improve services for people needing sensitive delivery and/or specialist services tailored to needs related to their ethnicity	NHS CB or SofS to commission NICE to seek opportunities to improve services for individuals and groups according to need when preparing Quality Standards or SofS to provide in regulations similarly in conferring functions in relation to other products and DH to monitor progress
Disability	Transfer of public appointments function from the Appointments Commission could disproportionately negatively affect people with disabilities seeking public appointment on merit.	DH will support CO & GEO in ensuring a comprehensive programme is in place to attract people including those with disabilities into applying for posts. DH intends to continue with AC's 'best practice' regarding the handling of the Recruitment & Selection process.
	Quality standards and guidance developed by NICE could positively improve services for people needing sensitive delivery and/or specialist services tailored to needs related to their disability. This includes all kinds of	NHS CB or SofS to commission NICE to seek opportunities to improve services for individuals and groups according to need when preparing Quality Standards or SofS to provide in regulations similarly in conferring functions in relation to other products and DH to monitor progress

	disability, including physical, psychological and learning disabilities.	
	Transfer of innovation and improvement initiatives to the NHS Commissioning Board could adversely affect people with all kinds of disabilities if there is a diminution of these initiatives as a result of the transfer	NHS Commissioning Board and NHS III until abolition to continue to promote leadership of innovation particularly to address issues of current inequality.
	Introduction of oversight by CHRE of voluntary registers will lead to potentially greater assurance about the standards of competence and conduct of unregulated health care professionals and occupational groups in the UK and social care workers in England. This should have a disproportionately positive impact on those people with disabilities who use their services	
	NPSA: Those with disabilities use health services proportionally more than some other demographic groups. This means there is the potential for those with disabilities to be at increased risk from patient safety errors. The NPSA reported in 2004 that people with learning disabilities are at greater risk from some types of patient safety incident (NPSA, 2004).	NHS Commissioning Board and NPSA until abolition to continue to address issues of current inequality.
	If the Board takes over from IC decisions on the commissioning of information about disabled or other groups with protected characteristics, including those with physical, psychological and learning disabilities, given the number and variety of the Board's other functions, might there be a diminution of quality in how the commissioning of information from the IC is carried out?	Ensure the Board has appropriate membership including knowledge of equality issues and is supported by IC on data issues
Gender	Quality standards and guidance developed by NICE could positively improve services for people needing sensitive delivery and/or specialist services tailored to needs related to their gender	NHS CB or SofS to commission NICE to seek opportunities to improve services for individuals and groups according to need when preparing Quality Standards or SofS to provide in regulations similarly in conferring functions in relation to other products and DH to monitor progress
	In terms of potential redundancies/transfers there is	We expect GSCC and HPC to ensure that all staff affected by the transfer

	likely to be a negative effect on GSCC female staff who make up the majority of the GSCC workforce.	are treated fairly and with respect. This will be supported by a Social Work Regulation Oversight Group
Pregnancy and Maternity	Quality standards and guidance developed by NICE could positively improve services for people needing sensitive delivery and/or specialist services tailored to needs related to their condition There is no evidence that patient safety or innovation for those giving birth will be negatively affected by these changes	NHS CB or SofS to commission NICE to seek opportunities to improve services for individuals and groups according to need when preparing Quality Standards or SofS to provide in regulations similarly in conferring functions in relation to other products and DH to monitor progress
Gender Reassignment	Quality standards and guidance developed by NICE could positively improve services for people needing sensitive delivery and/or specialist services tailored to needs related to their gender identity, including while in transition of reassignment Strengthening of information collection, access and use may be positively beneficial to design services for trans people for whom there is little or no information	NHS CB or SofS to commission NICE to seek opportunities to improve services for individuals and groups according to need when preparing Quality Standards or SofS to provide in regulations similarly in conferring functions in relation to other products and DH to monitor progress NHS IC to strengthen and expand its data collection and availability, meeting data requirements set down by NHS Commissioning Board
Marriage and Civil Partnership	There could be a negative impact on partners arising from changes on transfer to pension provision. Otherwise no negative or positive impacts on this equality strand are anticipated	The HR frameworks being developed to ensure fair treatment of all staff transferring between organisations will include consideration of the pensions issue
Age	Quality standards and guidance developed by NICE could positively improve services for people needing sensitive delivery and/or specialist services tailored to needs related to their age Transfer of innovation and improvement initiatives to the NHS Commissioning Board could adversely affect people of different age groups if there is a diminution of these initiatives as a result of the transfer	NHS CB or SofS to commission NICE to seek opportunities to improve services for individuals and groups according to need when preparing Quality Standards or SofS to provide in regulations similarly in conferring functions in relation to other products and DH to monitor progress NHS Commissioning Board and NHS III until abolition to continue to promote leadership of innovation particularly to address issues of current inequality.
	Introduction of oversight by CHRE of voluntary registers will lead to potentially greater assurance about the standards of competence and conduct of unregulated health care professionals and occupational groups in the UK and social care workers in England. This should	

	have a disproportionately positive impact on those older people, young people and children who use the services of health care workers and social care workers in England more than the general population	NPSA: There is some evidence that older people are more at risk from certain adverse events	NHS Commissioning Board and NPSA until abolition to continue to address issues of current inequality.
Sexual Orientation	Quality standards and guidance developed by NICE could positively improve services for people needing sensitive delivery and/or specialist services tailored to needs related to their sexual orientation	Strengthening of information collection, access and use may be positively beneficial to design services for lesbian, gay and bisexual people for whom there is little or no information	NHS CB or SofS to commission NICE to seek opportunities to improve services for individuals and groups according to need when preparing Quality Standards or SofS to provide in regulations similarly in conferring functions in relation to other products and DH to monitor progress
	Transfer of innovation and improvement initiatives to the NHS Commissioning Board could adversely affect lesbian, gay and bisexual people if there is a diminution of these initiatives as a result of the transfer		NHS CB or SofS to direct IC to strengthen and expand its data collection and availability, meeting data requirements set down by NHS Commissioning Board or SofS
Religion or Belief	Quality standards and guidance developed by NICE could positively improve services for people needing sensitive delivery and/or specialist services tailored to needs related to their religion or belief	Strengthening of information collection, access and use may be positively beneficial to design services for people of different faiths or beliefs for whom there is little or no information	NHS Commissioning Board and NHS III until abolition to continue to promote leadership of innovation particularly to address issues of current inequality.
			NHS CB or SofS to commission NICE to seek opportunities to improve services for individuals and groups according to need when preparing Quality Standards or SofS to provide in regulations similarly in conferring functions in relation to other products and DH to monitor progress
Socio-economic Status	Quality standards and guidance developed by NICE could positively improve services for people needing sensitive delivery and/or specialist services tailored to needs related to their socio-economic status		NHS CB or SofS to direct IC to strengthen and expand its data collection and availability, meeting data requirements set down by NHS Commissioning Board or SofS
			NHS CB or SofS to commission NICE to seek opportunities to improve services for individuals and groups according to need when preparing Quality Standards or SofS to provide in regulations similarly in conferring functions in relation to other products and DH to monitor progress

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Equality Impact Assessment

Annex F: Liberating the NHS – Public Health Service

Introduction

- F1. The Department of Health, NHS White Paper: ‘Equity and Excellence: Liberating the NHS’ announced a number of proposals relating to the creation of a public health service for England alongside the wider announcements of the reform of the NHS. This is an assessment on the legislative changes proposed on the face of the forthcoming Bill which include:
- At a national level, disestablishing the Health Protection Agency (HPA) and transferring the responsibilities and associated workforce to the Secretary of State
 - At a local level, transferring the responsibilities for health improvement, including the post of Director of Public Health, from NHS Primary Care Trusts (PCTs) to Local Authorities (LAs)

Why a change is necessary

- F2. The Government is determined to have a stronger, more effective public health strategy. Despite people’s best efforts, results in recent years have been disappointing, and this country still lags behind comparable countries in a number of areas.
- F3. As a nation, we are living longer, healthier lives than ever before. However, we know that too many of us damage our health through the choices we make in living our lives and we know that we need to be ever-vigilant in protecting people from hazards to health (such as infectious diseases) where individuals cannot readily protect themselves. In addition, wider social determinants such as housing and education impact on health with Marmot¹ finding that health inequalities result from social inequalities and that the lower a person’s social position, the worse his or her health. This contributes to the disproportionate burden of ill health borne by older people, people from Black and minority ethnic communities and people with a disability. The effect is real and serious – the average life expectancy of people with a severe mental illness, for example, can be 10 – 20 years below that of the population as a whole.
- F4. The current public health system has grown up piece-meal and as a result is not making the most of potential synergies across services. There is also little freedom for local communities to design and deliver local solutions for the particular challenges they face. By transferring responsibility for public health improvements from PCTs to local authorities, those responsible for commissioning public health services will be better able to work in a coordinated manner across the local authority to tackle issues such as lower educational attainment, insecure employment, poor housing and material disadvantage.

Scope of the EIA

- F5. This EIA should be read in conjunction with the EIA and impact assessment for the Public Health White Paper ‘*Healthy Lives, Healthy People*’¹¹³. The EIA for the Public Health White Paper predominately focuses on the policy intentions relating to the creation of the public health service including:
- The Structure of the public health service
 - Commissioning routes
 - The proposed ring fenced budget

¹¹³ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121941

- Outcomes framework
 - Information and intelligence
- F6. In addition, there is one discrete policy area which needs an individual impact assessment: the proposed increase in health visitor numbers.
- F7. The publication of *'Healthy Lives, Healthy People'* launched a consultation process on elements of the public health service. A further equality impact assessment will be published after the consultation has ended. This EIA is a final assessment on the high-level legislative proposals within the Bill. However, it must be taken in the context that much of the practical implementation will occur at a local level. In addition, some of the detailed proposals or approaches to implementation as set out in the related consultation documents and within the white paper.
- F8. The proposed legislative changes discussed within this assessment are not open to consultation but are subject to the passage of the Health and Social Care Bill.
- F9. A fuller story on the health of England is set out in *Our Health and Wellbeing Today*¹¹⁴, published to accompany *'Healthy Lives, Healthy People'*. This paper and the equality impact assessment has helped shape the content of the public health white paper.
- F10. Although socio-economic deprivation is not one of the protected characteristics in law, the DH has agreed to assess the impact as a way of addressing the broader health inequalities within the EIA, and a renewed focus on the inequalities produced by socio-economic deprivation and wider resulting inequalities is inextricably linked with the disproportionate burden of ill health affecting those covered by the protected characteristics.

Relevance to Equality and Diversity

- F11. The purpose of this equality impact assessment (EIA) is to inform development of this policy so that, as far as possible, it:
- (ix) Eliminates discrimination and does not generate or exacerbate inequalities in access to healthcare or health outcomes for patients and the public or employment and progression opportunities for actual/potential employees;
 - (x) Supports local efforts to reduce inequalities, promote equality and foster good relations between people from protected groups and those who are not.
- F12. In carrying out this assessment, we have considered the following dimensions:
- Age
 - Disability
 - Gender reassignment
 - Pregnancy and maternity
 - Race or ethnicity
 - Religion or belief
 - Sex
 - Sexual orientation
 - Socio-economic status
- F13. We have chosen to include all the relevant protected characteristics covered by the Equality Act in accordance with good practice guidance from the Equalities and Human Rights Commission

¹¹⁴ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122088

(EHRC). Not all the provisions of the Equality Act are yet in force; some, such as the prohibition on age discrimination in services and public functions are still under consideration, and the public sector equality duty is due to commence in April 2011. Our consideration of these characteristics takes into account that we expect these measures to be in force when these provisions come into effect.

- F14. Socio-economic status is not one of the protected characteristics that must be covered in the public sector equality duty and therefore in the EIA, but has been included for completeness of impact on current health inequalities.
- F15. In addition, where a change affects employment of staff, the effect on marriage and civil partnerships is considered. Some of the provisions in the Bill give effect to policies which will have an impact on staff currently employed in existing or new bodies. The three organisations concerned (the Department of Health, NHS and DH's arm's length bodies) are developing Human Resources frameworks based on common principles to ensure that staff whose employment is affected by the system reconfiguration are treated fairly and equitably. These principles, which will inform and determine the frameworks' individual content, will be agreed with Trade Unions. The composition of the initial frameworks is subject to consultation with Trade Unions as will be any revisions to the frameworks.
- F16. One of the principles, equality, recognises the importance of a diverse workforce and will help to ensure that no employee receives less favourable treatment on the grounds of age, disability, gender re-assignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, gender or sexual orientation, or on the grounds of trade union membership.

The Equality Act 2010 and powers of the Secretary of State

- F17. The Equality Act aims to simplify, harmonise and strengthen equality law, replacing nine major pieces of legislation and around 100 other instruments with a single Act. It received Royal Assent on 8 April 2010. The main provisions in the Act came into force in October 2010 and the single public sector equality duty will come into force in April 2011ⁱⁱ.
- F18. The single public sector equality duty covers race, disability, and gender (existing duties), plus age, sexual orientation, religion or belief, pregnancy and maternity, and gender reassignment. These dimensions are collectively referred to as the protected characteristics. All public bodies, including those changed or set up through these provisions, must have due regard to the need to:
- eliminate unlawful discrimination, harassment, and victimisation;
 - advance equality of opportunity; and
 - foster good relations between those who share a relevant protected characteristic and those who do not.
- F19. This general duty is underpinned by specific duties, to help public bodies meet the general duty. The Government has recently undertaken a public consultation on the specific duties.
- F20. The Equality Act 2010 will ensure that all public bodies within the health service, including the NHS and the public health service, are obliged to comply with principles of equality. This will include those bodies established under the Bill, such as GP consortia, and those whose functions are changed, such as some of the arm's-length bodies (CQC, NICE and Monitor). These duties also apply to private providers in so far as they are providing NHS services, on the basis that the provision of services for the purposes of the health service is a function of a public nature. This

can be brought about by measures such as the inclusion of contractual terms relating to equality in contracts with such organisations, where this is considered necessary.

F21. The sections consider the relevance to equality on the following themes:

Transfer of staff from the HPA and Other Bodies to the Department of Health (DH).

F22. We would expect all staff and assets associated with the responsibilities to transfer to the DH. We have not considered here any potential future reductions in posts, which may need to be achieved to meet the wider government cost-reduction programme. The HPA is one of the Department's Arms Length Bodies (ALBs). A separate work programme is taking forward proposals for changes to the ALBs.

Transfer of Directors of Public Health and other staff from PCTs to Local Authorities

F23. Each PCT currently has a Director of Public Health and staff working on public health matters. In order to deliver their public health improvement function, the Bill would require local authorities to have a Director of Public Health (DPH). The Department's current policy is that the existing PCT DsPH would transfer to local authorities. Centrally, it would be inappropriate to dictate whether all public health staff currently working in PCTs will transfer to local authorities, as local authorities need to be able to determine workforce requirements in line with business need ensuring due regard to employment legislation. Local authorities and PCTs have similar duties under equality and employment legislation and the transfers will comply with those duties.

Transfer of functions from NHS to local authorities

F24. Whilst the changes outlined above would largely affect staff, the transfer of public health functions from NHS PCTs to local authorities has the potential to impact on the services provided to patients and service users.

Summary of Evidence

F25. The individual EIAs rely on evidence and stakeholder feedback to:

- provide supporting evidence where actual or potential impacts on equality were identified
- assist with developing proposals for mitigating potential negative impacts
- demonstrate how proposed reforms can promote equality where possible

F26. The evidence used has been both qualitative and quantitative, and includes research papers, evaluation reports, census data, patient and public surveys, guidance, independent inquiries, health outcomes data and NHS workforce data. This intelligence was obtained from a range of organisations and sectors. In considering the policy options presented in this assessment we have taken into account the existing evidence base on public health and health inequalities, which is discussed further in the Evidence Base at Annex A. This demonstrates an understanding of some of the broader equality issues that need to be considered as changes to the system are finalised and implemented. Sections of particular note are organisational forms, engagement with public health professionals and the Joint Strategic Needs Assessments (JSNA) report from Race for Health and Shared Intelligence. A document detailing the evidence base relating to Public Health will be published alongside the Public Health White Paper.

F27. The Centre for Health Economics, University of York suggested that "organisational barriers have potentially become more significant recently due to the proliferation of different types of services, governed by different health professionals all of who have their own idea of an 'ideal user'.

Navigation of an entry point into such services may therefore be more difficult for those from disadvantaged groups.ⁱⁱⁱ The transfer of Directors of Public Health to local authorities presents the opportunity to better align health with social care. The Department of Health's Integrated Care Pilot programme is exploring different ways of delivering more patient-centred and joined up services. A progress report was published in November 2010¹¹⁵.

- F28. Race for Health and Shared Intelligence were commissioned by the Department of Health to prepare a report exploring approaches taken by Joint Strategic Needs Assessments (JSNAs) to understand race equality in health and healthcare. There is further work that could be done within the JSNA process to ensure that equalities issues are linked to local evidence on social determinants^{iv}.
- F29. On 16 September 2010, the UK Faculty of Public Health (FPH) published results^v of a survey sent to 3,300 public health specialist members (of which 1,160 members responded) asking for feedback in response to the White Paper, *Equity and Excellence: Liberating the NHS*. There were two questions directly relevant to equality issues. 91.3% agreed that the emphasis on the equity of outcomes is welcomed by the FPH. The majority of surveyed members (59.1%) expressed neutral views about whether the introduction of a new health premium would promote action on reducing inequalities. However, there were more positive responses than negative. (29.5% compared to 11.4%). Overall, members did not feel able to assess (53.3%) at that time whether they believed the White Paper proposals would lead to an improvement in the health of the population of England

Summary of Stakeholder Feedback

- F30. As part of the wider consultation process on *Equity and Excellence: Liberating the NHS*, a number of voluntary and equality organisations submitted formal feedback. The predominant focus was not on the proposals relating to the Public Health Service. A number of organisations gave feedback on the proposals relating to the public health service and they are referenced below.
- F31. The National LGB&T Partnership raised concerns that the changes proposed in the NHS White Paper will give local authorities more power over health and social care services without challenging them to take into account the needs of vulnerable minority groups, namely LGB&T communities, which many have been reticent to do thus far. However, the organisation recognised that some local authorities are making a worthwhile effort to engage with LGB&T communities and that their enlightened approach should serve as a model for those whose performance falls short of best practice. Local Authorities, like other public sector bodies have a responsibility to impact assess services and to take into account the needs of diverse groups of people including LGB&T communities. We would therefore expect local authorities to fully reflect the needs of their populations within such assessments. In addition, there will be additional accountability to the local population through the Health and Well-being boards.
- F32. The Samaritans were broadly supportive of the proposals in relation to public health suggesting that "the new role of local authorities in the delivery of public health services opens up the opportunity to deliver services aimed at improving public mental health and well being, designed specifically around the needs of the local community".
- F33. We are engaging with a wide variety of organisations and will continue to do so through the development of the public health services. As an example of this, a 'roundtable' was held with the Minister of State for Care Services in relation to public health and the voluntary sector on the 20

¹¹⁵ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121979

October 2010. Feedback suggested that the focus on wider social determinants was a positive step and that the voluntary sector could play a significant role. For example, the voluntary sector is a trusted voice that speaks for those who cannot or feel unable to speak for themselves and is a valuable resource for the public health service given the large number of organisations, and volunteers.

Discussion of Potential Impacts

Staffing the Public Health Service – Transfer of HPA and the transfer of Directors of Public Health.

- F34. The over-riding policy objective is to protect the public, and to improve the healthy life expectancy of the population, improving the health of the poorest, fastest, by establishing a unified public health service incorporating both national and local structures. The public health service will need to be staffed appropriately to achieve these objectives. This will also need to be looked at in the context of the wider structural reforms for the NHS, which will see the disestablishment of SHAs and PCTs.
- F35. We recognise that this may be a time of uncertainty for staff and it will be important to communicate clearly with staff. In developing policy options, it has been important to involve them and consider advice from front-line staff such as Directors of Public Health currently in post. To this end, there are a number of Directors of Public Health who are working for the Department on a part time basis. In addition, there is regular engagement with directors of public health through an advisory group. Staff within the HPA will be kept informed of developments relating to the transfer through a fortnightly bulletin although formal consultation has not yet been commenced.

Transfer of staff from the Health Protection Agency to the Department of Health

- F36. Given the vital nature of their work, we will need to ensure public health expertise and workforce is not lost but located elsewhere. In order to achieve cost efficiencies to respond to the financial challenge facing the public sector we will need to consider maximising the use of corporate services and minimising duplication in activity across different organisations. Be that as it may, at this stage, we would expect all staff and assets associated with the HPA to transfer to the DH. Equally, with regard to the transfers of Directors of Public Health (and associated staff) we would assume that any later reductions in staffing numbers would be the responsibility for the local authority in question to determine, taking account of relevant equality and employment legislation.
- F37. The HPA have published extensive data⁴¹ on the composition of the workforce by equality strand and have sought to improve the information on staff ethnicity, disability and sexual orientation. By bringing the HPA into the DH, we have the opportunity to collect detailed equality data which can be used to better understand and support the workforce, including addressing negative impacts on any group.
- F38. The HPA is made up of 11 divisions incorporating corporate functions such as finance, communications and HR and specialist functions such as the Regional microbiology Network. The following charts by protected characteristics have been produced using data from the HPA workforce report.

Demographic Data of HPA Workforce

Gender	Female	Male	Total
Number of staff (headcount)	2593	1508	4101
Percentage of staff (headcount)	63.23%	36.77%	100%

Ethnic Origin	White	Mixed heritage	Asian	Black	Chinese	Other	Filipino	Unknown	Total
Number of staff	2797	51	285	125	34	45	2	762	4101
Percentage of staff	68.20%	1.24%	6.95%	3.05%	0.83%	1.10%	0.05%	18.58%	100%

Religious Beliefs and Beliefs of Staff	Number of Staff	Percentage of Staff (%)
Atheism	202	4.9
Buddhism	14	0.3
Christianity	785	19.1
Hinduism	54	1.3
Islam	27	0.7
Jainism	9	0.2
Judaism	6	0.1
Sikhism	4	0.1
Other	110	2.7
Undefined	2588	63.1
Don't wish to disclose	308	7.5
Total	4101	100

Sexual Orientation	Bisexual	Gay	Heterosexual	Lesbian	Undefined	Don't wish to disclose	Total
Number of staff	8	11	1230	5	2583	264	4101
Percentage of staff	0.20%	0.27%	29.99%	0.12%	62.98%	6.44%	100%

F39. In addition to the charts above, the HPA report explained that 13 staff within the HPA declared that they had a disability. The HPA has supported the development of the LGBT staff support group, BME staff support group and women's staff support group. The Department of Health offers similar support mechanisms.

F40. An advice note for public authorities issued by the Equality and Human Rights Commissionⁱⁱ states that decisions such as efficiency drives, budget cuts, reorganisations and relocations, redundancies and service reductions could have a disproportionate impact on certain groups of people. The Equality and Human Rights Commission also note that there have been recent press reports which have suggested that women are more likely to be impacted for example due to revisions to maternity and/or flexible working policies. Approximately 2/3 of the HPA workforce are female and policy makers will need to be mindful of the increased likelihood of impact. Although we anticipate moving all staff from the HPA to the DH on the 1 April 2012, the DH has to be mindful of the need to cut costs across government and the HPA cannot be immune to this. However, at this stage, it is too early to speculate on the internal structure of the Department

after this date. A Human Resources Framework is being developed which will ensure that all ALBs take account of equality issues in taking forward any changes.

- F41. Another area of concern associated with restructuring is possible relocation. The Joseph Rowntree Foundation^{viii} suggests that “Employers’ assistance for relocating employees is focused predominantly on the financial aspects of moving house. However, there is increasing evidence of the impacts relocation has on partners’/spouses’ jobs, children’s education and care for older relatives. Yet many employers remain unwilling to take account of these wider issues. There is also for example a risk that if an organisation in an urban centre is relocated, a greater proportion of BME staff may be impacted.
- F42. At this stage we anticipate that staff and assets will transfer from the HPA to the DH. The HPA have a number of regional locations and we are not proposing any large scale move, for example to the DH buildings. This should mitigate against potential impacts resulting from relocation. Where appropriate, the transfer of staff will take place by virtue of TUPE or statutory transfer schemes with due consideration to equality legislation and employment law.

Transfer of Directors of Public Health to Local Authorities

- F43. The responsibilities that PCTs currently have for local health improvement will transfer to local authorities, who will employ the Director of Public Health, jointly appointed with the Public Health Service. From 2013/14, the DH will allocate a ring-fenced public health budget and local Directors of Public Health will be responsible for health improvement funds allocated according to relative population health need. The allocation formula for those funds will include a new “health premium” designed to promote action to improve population-wide health by promoting equality and reducing health inequalities. Further information on the health premium is included within the White Paper EIA.
- F44. Directors of Public Health currently have an important role within primary care trusts. The section below details the potential impact of transferring functions in more detail. The Association of Directors of Public Health (ADPH), the representative body for Directors of Public Health (DsPH) in the UK responded to the Consultation for Equity and Excellence: Liberating the NHS following significant consultation and involvement with members. The full consultation response can be found at the ADPH website. The ADPH recognise that the proposed structural changes in England raise huge opportunities for public health and the organisation welcome the increased formal role of local authorities in the health agenda. The integration of local Directors of Public Health into Local Authorities also opens the chance of real improvements in health and well-being. However, the ADPH also recognise that there are potential risks around staffing capacity and transition. The ADPH note that in previous reorganisations 10% - 15% of the specialist workforce have left the service.
- F45. Data on the demographics of Directors of Public Health is currently not held centrally. The Association of Directors of Public Health have provided statistics on the gender of their members including Directors of Public Health and those acting as interim and executives. These figures can only be seen as a broad indication and not definitive. The percentage of males to female is broadly equal with 47% being male and 53% being female.
- F46. The majority of Directors of Public Health will not need to “reapply” for their jobs but will instead transfer by virtue of TUPE or statutory transfers. Transfers, where appropriate will take place between PCTs and local authorities. Both types of organisations are well versed in their duties on equality and have previously experienced organisational change. Determining the wider public health workforce within a local authority will be the responsibility for the local organisation. Many

Directors of Public Health have already worked jointly between a PCT and a local authority with the Association of Directors of Public Health estimating

- F47. However, there are some areas where the number of PCTs does not align with the number of upper tier unitary authorities. In these cases there will be open and transparent competition for roles. This will need to be dealt with on a case by case basis but we would expect the process to comply with equality legislation. As further mitigation, there are currently vacancies at Director of Public Health Level. However, as discussed above we recognise that relocations can have an adverse impact on staff.

Diversity within Senior Leadership and the professions

- F48. There is evidence to suggest that there is not equality of opportunity in accessing career opportunities. For example:

- Women earn on average 23% less per hour than men. Women working part-time are paid around 40% less per hour^{ix}
- People of BME background are 13% less likely to find work than a white person^x
- Disabled people are still more than twice as likely to be out of work as are non-disabled people^{xi}

- F49. There are additional barriers to entering traditional professional occupations and senior executive positions both within the public and private sectors. For example, medicine is one of the most socially exclusive professions. A typical doctor born in 1970 grew up in a family with an income 62% above that of the average family, in today's terms, this equates to growing up in a family that is richer than five in six of all families in the UK^{xii}. There is limited data on the full demographic break down of the public health workforce. However, the Faculty of Public Health have undertaken a series of surveys^{xiii} from 2003 onwards, Of the 2648 workforce questionnaires that were circulated as part of the 2007 census, 1712 were returned and 939 were identified as working at a consultant level in public health and related areas. Of the 939 respondents, 50% were between the ages of 45 and 54 years of age. 49% were male. There was not detailed ethnicity information on 14.6% of the group but 65.8% described themselves as White British with the remainder from a wide variety of ethnic backgrounds.

Senior Leadership

- F50. Although the NHS is the largest employer of women, BME groups and gay and lesbian people across Europe, there is continued under-representation from minority groups at a senior level. The NHS has made extensive efforts to address this, for example through the Breaking Through Programme, which is a positive action programme to identify, select and develop talented managers and clinicians from BME backgrounds and support them to achieve director level positions. In March 2000, the Department of Health set up a survey^{xiv} to monitor progress on targets to increase the representation of women and black and minority ethnic groups on the boards of NHS organisations. On the 31 March 2004:

- 43% of executive directors were women.
- 7.5% of executive directors were in black and minority ethnic groups – (however this varied at the time from 0.00% in Dorset and Somerset to 28.3% in North East London).

- F51. Similar challenges are experienced within local authorities. Within the Local Government Workforce Survey: England 2010^{xv} local authorities were asked to state the percentage of the top five percent of earners from their authority who were from BME groups, had a disability or from BME groups.

14Percentage of the top 5% of earners within surveyed local authorities by ethnicity, disability and gender (adapted from the Local Government Workforce Survey)	
15BME Groups	162%
17Those with Disability	183%
19Women	2044%

F52. Local authorities were asked if they were taking any action to increase the percentage of BME groups in senior management positions. 46% of local authorities had already taken action or were planning to take action. 78% of local authorities monitored their workforce across equality strand. Four percent were not yet considering monitoring which is a risk for the organisations involved. However, 100% of local authorities that responded had mechanisms in place or were considering developing mechanisms to tackle any harassment or discrimination that may arise from the lack of diversity in their workforce.

Equality and Diversity: Local and Democratic Legitimacy

F53. The diversity of an organisation commissioning services, especially at its senior levels, is often perceived to influence its ability to commission for diverse populations. This is especially true in the case of elected local government. A potential risk is that Councillors are not representative of the population as a whole^{xvi}. In 2006, only 29% of councillors in England were women and 4.1% had a non-white ethnic background (compared to 9.5% of the population over 21 years old). The National Census of Local Authority Councillors for 2008 shows little change in these figures: 68.4% of councillors were male, with only 30.8% female. 3.4% came from an ethnic minority background compared with the percentage of BME people in the general population (9.5%). The average age of councillors has increased from 55.4 years in 1997 to 58.8 years in 2008. The proportion under 45 has fallen from 18.4% to 13.1% over the same period.

Transfer of functions from NHS to Local Authorities

F54. There is evidence to suggest that “social inequalities exist across a wide range of domains: age, gender, race, ethnicity, religion, language, physical and mental health and sexual orientation[...] These inequalities interact in complex ways with socio-economic position in shaping people’s health status.^{xvii}” There is a social gradient in health and the root causes of inequality have a profound impact on health outcomes.

F55. Transferring the local public health commissioning responsibilities to local authorities allows for tailored local solutions to meet widely varying local needs, and facilitates joined up approaches across many other areas of local government’s work (such as housing, planning, social care, and leisure) and with other important local partners (such as the police, business and schools) – all of which can have a huge impact on the wider determinants of health and wellbeing. In addition, unlike PCTs local authorities have a democratic mandate from the diverse local population, and can be held directly to account by that population for their performance.

F56. Local authorities have a public health role at present. In particular, they perform functions in relation to the control of disease under the Public Health (Control of Disease) Act 1984. The new policy is that “upper tier” local authorities are to be given additional responsibility for improving the health of their local population focusing on activities such as:

- influencing lifestyle choices by providing education and training, information and campaigns (an example would be campaigns highlighting the benefits of eating “five a day”, or pointing to the dangers of smoking);

- facilitating activity which improves health such as promoting leisure classes, working with other parts of local government to promote healthy activity (e.g. encouraging active travel, promoting exercise, reducing excess seasonal deaths through housing improvements, using existing social groups to increase skills to enable healthy eating and nutrition); and
- activities which prevent illness (a good example being smoking cessation classes which help smokers quit, thereby reducing the number of people who suffer from cancer and heart disease).

F57. In addition to health improvement functions, we propose transferring responsibility for fluoridation from Strategic Health Authorities to local authorities, transferring responsibility for school nursing and the weighing and measuring of children from Secretary of State and Primary Care Trusts to Local Authorities.

F58. Within each “upper tier” local authority, the responsibility for these functions will fall to a Director of Public Health appointed jointly by the local authority and the Secretary of State. It is proposed that the Director of Public Health will be responsible for a ring-fenced budget allocated to the local authority for its health improvement function. The Director of Public Health will have a duty to produce an annual report and we would expect this to include equality data based on the protected characteristics.

Public Health and the NHS

F59. Public Health England will work hand in hand with the NHS. There will be protected public health funding separate from the healthcare budget to ensure that it is not squeezed by other pressures, through it will still be subject to the running costs reductions and efficiency gains that will be required across the system. Directors of Public Health will be the strategic leaders for public health and health inequalities in local communities, working in partnership with the local NHS and across the public, private and voluntary sectors. We have also proposed new local statutory health and wellbeing boards to support collaboration across NHS and local authorities, in order to meet communities’ needs as effectively as possible.

F60. We believe that local authorities are best placed to deliver local public health services in the new system as opposed to GP consortia. Local authorities are likely to have a wider population base than a consortium, which may allow for greater economies of scale in providing (or commissioning to be provided) public health interventions. In addition, local authorities are better placed to consider the full substitutability and complementarity of different services that may deliver public health outcomes when commissioning services.

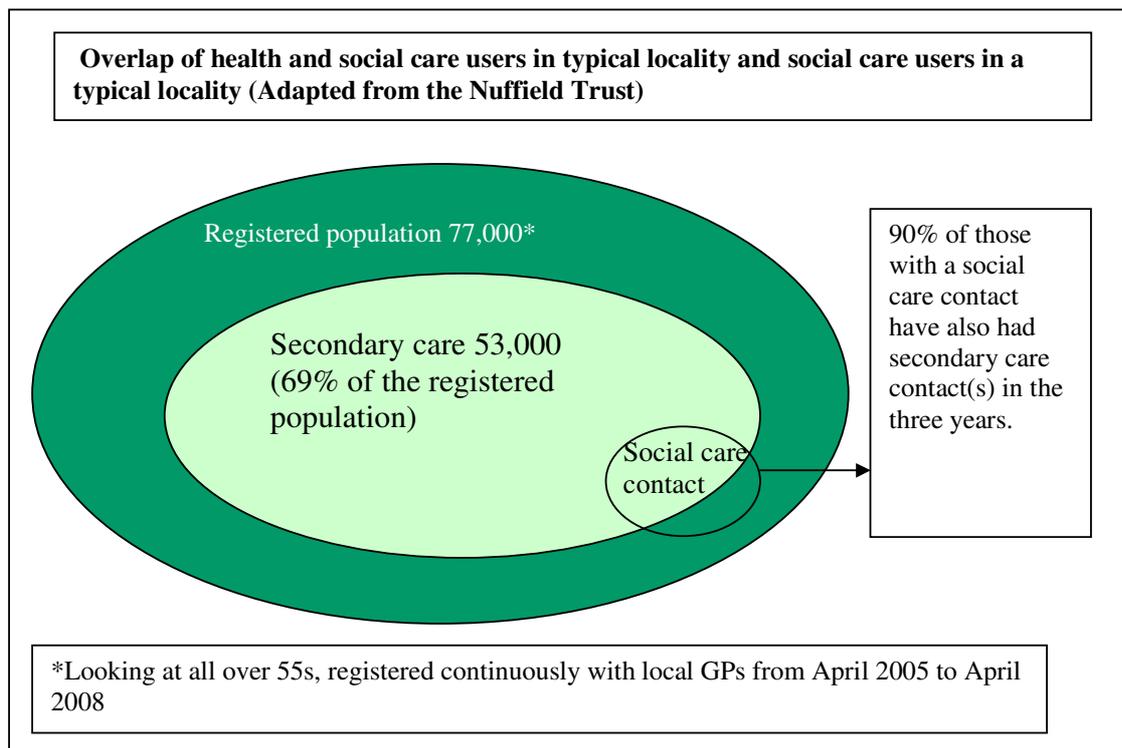
F61. While commissioning consortia will be responsible for the whole local population there is a risk that public health interventions that rely heavily on GPs for delivery will overlook those not registered with a GP practice, who are likely to include some of those who would benefit most from those interventions. This could have the effect of deepening health inequalities. For example, evidence suggests that homeless people and those sleeping rough tend to be more likely than the general population not to be registered with a general practitioner.¹¹⁶ Furthermore, a 1994/95 survey covering 117 GP practices in and around Bristol found that only 27% would permanently register a homeless person, with 24% only treating homeless people on an emergency basis.¹¹⁷ This might mean that homeless people would be unlikely to receive preventative treatments.

¹¹⁶ Anderson et al (2003) Single homeless people, London: HMSO

Allen and Jackson (1994) Health care needs and services in resettlement units, London Policy Studies Institute for the Resettlement Agency and Department of Social Security

¹¹⁷ Wood et al (1997) Do homeless people get a fair deal from General Practitioners?, Journal of Royal Society of Health 117(5):292-297

F62. There is however, a risk of fragmentation. Currently people belonging to a vulnerable group (for example those people who are at particular risk of ill-health and who would benefit most from public health interventions) would have their health services provided or arranged by one local body (PCT). In the current system, there will be two commissioning bodies. However, a narrow focus on health takes too simplistic a view of the current system. For example, whilst an older person with a long-term condition may have their health services commissioned by the local PCT, they may well benefit from services provided by the local authority such as social services. Indeed, currently there already a degree of fragmentation where a service user has contact with social and health services. For example, research by the Nuffield Trust^{xviii} showed that in a typical locality, 90% of social care users over the age of 55 had been in contact with secondary care during a three year period.



F63. There are a number of organisations where there is joint leadership between the local authority and the primary care trust such as NHS Herefordshire (Primary Care Trust) and Local Authority. The organisation notes positive outcomes such as more older people with mental health problems are able to live safely and with dignity in their own homes and a joint focus on improving health and wellbeing outcomes. For example, there is now a more coherent approach to tackling childhood obesity. By moving public health commissioning responsibilities to local authorities, we would expect a greater understanding of the wider social determinants at a population level.

Diversity of Supply

F64. Potential benefits of commissioning a more diverse range of services could include increased innovation. This is of particular relevance to public health services, where ill-health and inequalities may reflect social and cultural factors. Improvements in public health are therefore more likely to require innovative approaches to tackling behaviour change.

- F65. In commissioning services, Local Authorities as public bodies will also need to be aware of and meet the obligations and duties set out in equality legislation. They will be supported to do this by a ring-fenced budget. We expect the overall impact on equality to be positive. Local authorities will have a responsibility to impact assess the services they deliver and will be held accountable at a local level for the services delivered.
- F66. There is however a risk that some inequalities could remain entrenched, for example because of:
- inadequate commissioning
 - a lack of high quality local suppliers
 - or a set of nationally determined outcomes which focus efforts on particular groups to the detriment of others.
- F67. To avoid this, the DH will need to ensure the Outcomes Framework (detailed within 'Healthy Lives Healthy People and the accompanying consultation document') is sufficiently flexible to allow for local authorities to address the needs of disadvantaged groups in their areas. Local authorities will need to monitor the health status of local groups, and adjust commissioning strategies as necessary.

Local Authorities and Equality

- F68. The policy will transfer responsibility for public health commissioning from PCTs to Local Authorities, which is designed to locate responsibility for promoting the public's health with a single organisation locally, which is best-placed to deliver health improvements, working across the range of its functions to deliver policies which tackle the wider determinants of health (e.g. housing, transport), whilst also promoting positive behaviour change (e.g. through promoting leisure activities, smoking cessation). One way in which this will happen is by local authorities using their commissioning powers to increase the diversity of suppliers, opening up the market to those that are well-placed to identify and address the needs of disadvantaged groups. The Government will set national outcomes for public health and introduce incentive payments for local authorities that chose to work towards them.
- F69. Local authorities are already well-versed of their responsibilities under equality and human rights legislation. The proposed changes will add further functions across which they will exercise these responsibilities, supported by a ring-fenced budget to deliver those new responsibilities. In addition, local authorities already provide and commission a range of services and have a wider corporate knowledge of issues relating to wider social determinants. They will need to use existing resources such as The Equality Framework for Local Government¹¹⁸ to continue to make progress in mainstreaming equality.
- F70. A focus on localism does however bring increased responsibility. There is evidence to suggest that there are excellent examples of good practice in relation to equality and diversity in both PCTs and local authorities but there is also room for improvement within both types of organisation.
- F71. For example, in September 2007, the Disability Rights Commission (DRC) conducted a review^{xix} of Disability Equality Scheme assessments by primary care trusts to determine their overall compliance with the Disability Equality Duty, (now superseded by legislation contained within the Equality Act 2010). Out of the 152 PCTs a sample of 20 was chosen to reflect the national speak of BME communities, population density and rural/urban areas. The DRC found that Only two of the schemes were assessed as being compliant and the requirement of involving disabled people

¹¹⁸ <http://www.idea.gov.uk/idk/core/page.do?pageId=9491107>

in developing PCT schemes was only properly fulfilled in 3 schemes. Evidence gathering and impact assessment were consistently weak across most of the schemes.

- F72. In 2003 the Office of the Deputy Prime Minister conducted a review into equality and diversity^x in local government in England. The report found that In those areas of the country with significant and visible diverse communities, local authorities are likely to be more aware of both the pressures and opportunities that diversity brings. However, local authorities in those areas of the country that are perceived to be more homogeneous may not recognise these factors to the same extent. The report found that there was a growing emphasis on partnership working at a local level with better joint working with statutory agencies, private, voluntary and community sector organisations.
- F73. There is a risk that in moving to a more political environment, issues that are highly contentious or where there is a lack of electoral incentive may not be tackled in areas of the country where the equality agenda is less actively pursued. However, the creation of statutory health and wellbeing boards and the leadership role of the Director of Public Health should mitigate against this by providing a co-ordinating role and advice based on an understanding of the evidence and of the local populations needs.

Joint Strategic Needs Assessment and Health and Wellbeing Boards

- F74. The Department of Health recently consulted on proposals for local statutory health and wellbeing boards. During the consultation, there was support for local statutory health and wellbeing boards, with a desire to see clarity of accountability in the system between Local Authorities, GP consortia and the NHS Commissioning Board. Local government and the NHS have also wanted to see close partnership working and joined-up commissioning strategies between the NHS and Local Authorities. GP consortia and Local Authorities, including Directors of Public Health, will each have an equal and explicit obligation to prepare the (JSNA¹¹⁹), and to do so through the arrangements made by the health and wellbeing board. The health and wellbeing board will be able to establish a shared local view about the needs of the community and to support joint commissioning of NHS, social care and public health services to meet the needs of the whole local population effectively.
- F75. The JSNA process should ensure that local authorities have a good understanding of the needs of their population, and the ring-fenced public health budget should ensure they have resources to tackle issues identified in JSNAs including disadvantage and inequalities. However, we are aware that there could be further improvements to the way in which JSNAs tackle equality issues by better linking equalities issues to social determinants.^{xxi} Further information is available on JSNA¹²⁰ which includes the importance of stakeholder involvement and engaging with local communities.
- F76. Tackling Health Inequalities' (2003)^{xii} outlined what could be different from the status quo in terms of engaging communities and individuals. The report highlighted certain measures that would improve health inequalities, that the proposals for increasing local democratic legitimacy in health are compatible with. In particular:
- local people being involved in identifying health needs, influencing decision making and evaluating their local services;

¹¹⁹ . A joint strategic needs assessment is an assessment of the health and social care needs of the population in a local area and has been a statutory duty for Primary Care Trusts and Local Authorities to undertake one since 2008. They aim to establish a shared, evidence based consensus on key local priorities to support commissioning to improve health and wellbeing outcomes and reduce inequalities.

¹²⁰ <http://www.idea.gov.uk/idk/core/page.do?pageId=79427960>

- developing new ways of engaging communities in the planning and provision of services, and promoting communities to stimulate greater community participation in decision making; and
- recognising and making best use of links between specific health policies and those that are initiated outside of the Department of Health but play a key role in social support. E.g. employment and education policies.

F77. The policies of increasing local democratic legitimacy in health are consistent with the measures highlighted above. Specifically, by creating local health and wellbeing boards, local people, both sitting on the board, and having a say in who sits on the board (through democratic power), will be actively engaged the measures listed above. The creation of health and wellbeing boards therefore increases the opportunity of health inequalities being better catered for.

Support for Local Authorities

F78. The Local Government Association suggests that “councils and their partners have a real opportunity to challenge inequality, to ensure that everyone has an equal chance in life and to respond to the diverse needs of the communities they serve”. Local authorities are supported by the Equalities and Cohesion team at the Improvement and Development Agency which helps councils to meet these challenges by providing up-to-date information on equality policy and practice, such as where to find evidence and data, guidance on legislation and examples of good practice. Some examples of the good practice case studies are included below.

Richmond upon Thames’ peer mentoring approach to Equality Impact Assessments (adapted from Improvement and Development Agency for Local Government IDeA).

The London Borough of Richmond upon Thames uses a peer mentoring approach to Equality Impact Assessments (EIAs). This has helped the council to identify needs for service and policy areas. Service managers have gained knowledge and confidence in the understanding of EIAs. They can now use a more robust approach to equality action planning.

At Richmond, the approach to EIA is not just about trying to identify adverse or differential impact. It has been about making a baseline assessment of a service or policy area. This is to ensure that needs are identified and services are trying to meet these needs. The process is also used as a tool to help with equality action planning. This is why it is called the Equality Impact and Needs Assessment (EINA). During the mentoring process, five workshops were run on ‘How to Conduct an Equality Impact Assessment’. One was held for each directorate, so there was a focus on similar approaches and case studies. A drop-in session for problem solving was included with the workshop. Mentors also gave a presentation to equality leads, looking at the importance of EIA action plans and integrating the process into service planning. Examples of EIAs completed at London Borough of Tower Hamlets were used as examples of best practice.

Challenges

- Consultation and monitoring for EIAs was particularly challenging for managers.
- Managers had varying levels of knowledge and experience of conducting EIAs and equalities work in general.
- There was concern about data collection for sexual orientation and religion and or belief.
- Encouraging managers to link action plans to service plans so that equality objectives were mainstreamed.

Outcomes and impact

- Management ‘buy-in’ into the process of conducting EIAs.
- Managers now have greater knowledge and confidence to carry out EIAs.
- The work has supported a number of draft EIAs across the council, including replacement of the council’s website with a new website to provide both information and transactional services,
- Richmond has revised guidance to managers to say that all high-impact areas should undertake a full assessment and will review documentation.

- Mentors have gained a better understanding of service areas outside their own field of work. This was useful when trying to identify potential adverse and differential impacts. All corporate and generic data relevant to EIAs is now on one webpage.

1 Merton's travel training programme for vulnerable adults (adapted from Improvement and Development Agency for Local Government IDEA).

The London Borough of Merton has developed an initiative intended to improve the lives of vulnerable adults. The programme offers travel training to people with learning difficulties. This gives them the chance to gain independence, get a job, go to college or attend social and leisure activities. The initiative was guided by the recommendations in the Department of Health's (DH) 'Valuing People Now' document. It focuses on people having more choice and control over their lives and the services they use.

1.1 Challenges

The council researched the needs of service users with learning disabilities. It found that service users needed support to travel to and from a variety of locations throughout the borough. This could be to participate in work placements and employment, or leisure and social activities. The need for service users to receive travel training to build independence, awareness and confidence was discussed. It was agreed that developing these skills would help disabled service users contribute to and be part of the local community.

The council applied for funding from the Learning Disability Development Fund (LDDF). This application was successful and enabled Merton to appoint two travel trainers to present the travel training programme. Participants were supported to learn routes to a chosen destination in small groups or on a one-to-one basis. Trainees used a variety of modes of transport to attend educational classes, employment, and social and leisure activities. Trainees working towards independent travel were issued with personal travel wallets. This included a list of items to take on each journey, such as keys, money, freedom pass, taxi card, mobile phone and a personal alarm. The pack also includes emergency contact details, photographs of relevant landmarks and staff details at selected help points throughout their journey. Trainees who did not achieve independent travel continued to be supported by the travel trainers.

1.2 Outcomes and impact

- On a weekly basis approximately 20 service users entered the programme. Further support has been offered to help with work placements, college courses, therapy sessions and accessing leisure centres.
- One participant from the programme has now been offered a work placement and travels independently to and from their workplace. And another service user has overcome a fear of travelling in the rain. This person is no longer dropped to and from work placement when it is raining.
- Individuals are now going to their local shops, posting letters and visiting friends in their community without support. These life-changing skills have clearly increased service users self-esteem, motivation, confidence levels and the drive to achieve personal goals.

Overall Assessment of Impact

F79. The overall impact of the public health provisions of the Health and Social Care Bill will be positive. The main points are:

- Unifying accountability for public health in England under the Secretary of State for Health. The burden of poor health is not spread equally across society – older people, people with disabilities and people from BME backgrounds can, for example, all be more likely to experience preventable health problems. The Bill gives the Secretary of State a clear statutory duty to reduce inequalities, and the new role will place public health at the heart of the wider central government agenda for the first time.

- Giving local authorities the responsibility for improving the health of their local populations. The Bill says that local authorities must employ a director of public health, who will be supported by a new ring-fenced budget – a resource that has not been available to primary care trusts, who have had to balance spending on public health against the needs of acute services, for example. Local authorities are ideally placed to understand and meet the needs of diverse communities – and, unlike NHS organisations, are directly democratically accountable to those communities. The Bill requires directors of public health to publish annual reports that can chart local progress.
- Giving the Secretary of State the power to specify particular public health services that local authorities must provide, to ensure their national availability. This may include services that are especially important to people with protected characteristics.
- Giving local authorities the role of consulting on fluoridation of water supplies. Fluoridation can significantly reduce inequalities in oral health between affluent and less affluent areas but remains a controversial subject. Strategic health authorities currently have the responsibility to consult, and more work will be done to establish when the multiple local authorities within a water supplier's area will consult, and how they will reach a consensus.
- Giving local authorities specific functions around dental public health and around health checks for schoolchildren. Again these functions will be most valuable in less affluent areas, and the transfer to local authorities rather than to commissioning consortia will help ensure an integrated and connected health improvement service.
- Giving commissioning consortia the job of arranging wheelchairs and other vehicles for people with a physical disability. The consortia will be responsible for other specialist medical equipment so are best placed to provide a good service, but will also be able to work with local authorities where that is the best option.
- Abolishing the Health Protection Agency, transferring its staff to the civil service and its functions to the Secretary of State. Other than the positive contribution the abolition makes to unifying accountability under the Secretary of State, the impact on equalities should be neutral. The Department of Health will take care to carry out a fair and transparent transfer process, compliant with its responsibilities under equality and human rights legislation.

Recommended Actions

F80. We recognise that we are at an early stage of policy development in relation to the Public Health Service and that there are gaps in the evidence base. Therefore, we will commit to:

- develop an impact assessment (to include an equality impact assessment) for the Public Health White Paper which will provide additional detail on policy development.
- publish a further equality impact assessment after the close of the Public Health Service White paper consultation.
- involve stakeholders in policy development between the publication of the Public Health White Paper and the publication of the final assessment.
- arrange a workshop with DH colleagues to discuss equality issues to inform continued policy development
- include specific questions relating to equality and human rights issues in the consultation document
- encourage Directors of Public Health to take into account the recommendations outlined in the Race for Health and Shared Intelligence on JSNA practice in relation to race equality
- ensure the Public Health Service Outcomes framework properly highlights inequalities.
- Review the post-transition period

ⁱ Marmot, Fair Society, Healthy Lives: A Strategic Review of Health Inequalities in England Post-2010

ⁱⁱ From April 2012, the ban on age discrimination in provision of goods, facilities, services and public functions will

be implemented.

- iii University of York, Centre for Health Economics Quality in and Equality of Access to Healthcare Services in England, , August 2008
- iv Race for Health and Shared Intelligence, 'Joint Strategic Needs Assessment – 'Towards Culturally Responsive JSNAs''. August 2010
- v <http://www.fph.org.uk/news>
- vi Health Protection Agency (Workforce Monitoring Report Information on staffing and employment in the Health Protection Agency in 2009/2010
- vii Equality and Human Rights Commission, '*The Public Sector Equality Duties and financial decisions* : an advice note for public authorities
- viii Joseph Rowntree Foundation, 'The effects on families of job relocations'(2003)
- ix Office for National Statistics, General Household Survey, 2008
- x Office for National Statistics, Census 2001
- xi Office for National Statistics, Census 2001
- xii Cabinet Office, '*Unleashing Aspiration: The Final Report of the Panel on Fair Access to the Professions*' (2009)
- xiii Faculty of Public Health, 'Specialist Public Health Workforce in the UK: A report for the Board of the Faculty of Public Health (February 2008).
- xiv Department of Health, '*Survey to monitor NHS equalities & education targets*' (2004)
- xv Local Government Group, '*Local Government Workforce Survey England 2010*', (November 2010).
- xvi Department for Communities and Local Government: London, 'Duty to promote democracy: Equality impact assessment (August 2009)
- xvii Marmot, Fair Society, Healthy Lives: A Strategic Review of Health Inequalities in England Post-2010
- xviii The Nuffield Trust, 'Predictive Risk: The Way Forward', Martin Bardsley, Head of Research speaking at the PRIMIS+ Annual Conference (22 September 2010).
- xix Disability Rights Commission, '*Overview of Primary Care Trust Disability Equality Scheme assessments by the Disability Rights Commission*', 2007.
- xx Office for Public Management, 'Equality and Diversity in Local government in England, July 2003.
- xxi Race for Health and Shared Intelligence, 'Joint Strategic Needs Assessment – 'Towards Culturally Responsive JSNAs''. August 2010
- xxii Dept. of Health (2003) *Tackling Health Inequalities: A Programme for Action*. Report Cm6374. Dept. of Health, London

Table 1 – potential impacts on protected groups: Creation of the Public Health Service (Legislative elements of the Health and Social Care Bill)

The burden of poor health is not spread equally across society – older people, people with disabilities and people from BME backgrounds can, for example, all be more likely to experience preventable health problems. The Bill gives the Secretary of State a clear statutory duty to have regard to the need to reduce health inequalities, and the new role will place public health at the heart of the wider central government agenda for the first time. Given the social gradient and the wider social determinants that can impact on health, we would broadly expect a positive impact on inequalities. Please note that the EIA accompanying ‘Healthy Lives, Healthy People’ details further impacts in relation to broader workstreams such as the ring-fenced budget and the outcomes framework. These two policies (details of which are currently open to consultation) have enormous potential to tackle inequalities. To incentivise action to reduce health inequalities we will introduce a new health premium, which will apply to the part of the local public health budget which is for health improvement. Building on a baseline allocation that is weighted towards areas with the worst health outcomes, and most need, local authorities will receive an incentive payment, or premium, for these services that depends on the progress made on improving the health of the local population, based on elements of the proposed outcomes framework.

Protected characteristics	Potential impact	Opportunity to advance equality	Potential negative impacts of the policy	Identify potential or actual adverse impacts and mitigation
Disability (including carers of disabled people)	Positive	Given the strong focus and commitment to tackling inequalities, we would expect there to be a positive impact on this characteristic. Mental health will be a key part of the outcomes framework consultation.	There is evidence to suggest that people with mental health problems or learning disabilities have a lower life expectancy and there may be difficulties in accessing public health initiatives for example cancer screening.	Ensuring that people with disabilities (including mental, physical and mental health) have the access they need to services will be important. Equality impact assessments will be carried out where appropriate for national and local initiatives to ensure that issues such as access are considered.
Gender, gender reassignment	Neutral	We would hope that the strong focus and commitment to tackling inequalities would have an impact but we do not have particular evidence to support this at present.	Women tend to be seen as ‘healthier’ than men. There is a risk that the needs of women (particularly around birth and maternity services) will be overlooked	The government has announced a commitment to increasing the number of health visitors which will better support early years interventions. Equality impact assessments will be carried out where appropriate for national and local initiatives to ensure that issues such as access are considered.

Protected characteristics	Potential impact	Opportunity to advance equality	Potential negative impacts of the policy	Identify potential or actual adverse impacts and mitigation
			<p>Councillors are not representative of the population as a whole^{xviii}. In 2006, only 29% of councillors in England were women.</p> <p>Men are less likely to access primary care for example cognitive behavioural therapy (CBT) for depression</p> <p>Women may be disproportionately impacted by organisational change.</p>	<p>The proposed creation of the local health and wellbeing boards will allow local people to both sit on the board, and have a say in who sits on the board (through democratic power), will be actively engaged the measures listed above. The creation of health and wellbeing boards therefore increases the opportunity of health inequalities being better catered for.</p> <p>Local initiatives need to recognise and address behavioural differences between men and women.</p> <p>Where appropriate, the transfer of staff will take place by virtue of TUPE or statutory transfer schemes with due consideration to equality legislation and employment law. The organisations concerned (the Department of Health, NHS and DH's arm's length bodies) are developing Human Resources frameworks based on common principles to ensure that staff whose employment is affected by wider system reconfiguration are treated fairly and equitably. These principles which will inform and determine the frameworks' individual content have</p>

Protected characteristics	Potential impact	Opportunity to advance equality	Potential negative impacts of the policy	Identify potential or actual adverse impacts and mitigation
				been agreed with Trade Unions.
Gender reassignment	Neutral	We would hope that the strong focus and commitment to tackling inequalities would have an impact but we do not have particular evidence to support this at present we would expect	Lack of data on trans service users, could lead to inadequate needs assessment and inequities in service provision	The Department of Health Equality and Inclusion team will be working with the Equality and Human Rights Commission (EHRC) to help strengthen the evidence base on the health needs of trans people.
Race,	Positive	Given the strong focus and commitment to tackling inequalities, we would expect there to be a positive impact on this characteristic.	Race for health and shared intelligence were commissioned by the department of health to prepare a report exploring approaches taken by joint strategic needs assessments (JSNA) to understand race equality in health and healthcare. There is further work that could be done within the JSNA process to ensure that equalities issues are linked to local evidence on social determinants ¹ .	Local authorities have a wide range of support materials available in supporting the impact assessment process. Best practice examples have been included within this EIA. Local authorities need to involve BME communities in planning and delivery interventions.
			Councillors are not representative of the population as a whole ^{xxiv} . In 2006, only 4.1% had a non-white ethnic background (compared to 9.5% of the population over 21 years old).	The proposed creation of the local health and wellbeing boards will allow local people to both sit on the board, and have a say in who sits on the board (through democratic power), will be actively engaged the measures listed above. The creation of health and wellbeing boards therefore increases the opportunity of health inequalities

Protected characteristics	Potential impact	Opportunity to advance equality	Potential negative impacts of the policy	Identify potential or actual adverse impacts and mitigation
Religion or belief	Neutral	We understand that cultural beliefs within communities may be a barrier for accessing services. Banton and Johnson ^{xxv} suggest that “Time and time again alcohol use, especially problematic use, is viewed as something that should not be disclosed to others within and outside the South Asian and African Caribbean communities”. There is a risk that a lack of understanding amongst professionals on issues relating to religion may exacerbate existing barriers. There is also a lack of information on religion or belief when compared to other protected characteristics.	There is a risk that a lack of information on religion will make it difficult for commissioners to understand the needs of the population.	The collection of disaggregated data is needed to ensure commissioners are able to adequately take into account the needs of their population. We would also expect local authorities to involve local faith groups in the decision making (or if appropriate delivery) of public health interventions and to make full use of the mixed economy of service providers
Sexual orientation	Neutral	We would hope that the strong focus and commitment to tackling inequalities would have an impact but we do not have particular evidence to support this at present.	The national LGB&T partnership raised concerns that the changes proposed in the NHS white paper will give local authorities more power over health and social care services without challenging them to take into account the needs of vulnerable minority groups.	Local authorities have a responsibility to assess services and take into account the needs of diverse groups including LGB&T communities. We would therefore expect local authorities to fully reflect the needs of their populations within such assessments. In addition, there will be additional accountability to the local population through the health and well-being boards.
Age	Positive	Given the strong focus and commitment to tackling inequalities, we	There is a risk older people may be disproportionately impacted by	With regards the workforce transfers, we need to consider any future

Protected characteristics	Potential impact	Opportunity to advance equality	Potential negative impacts of the policy	Identify potential or actual adverse impacts and mitigation
		<p>would expect there to be a positive impact on this characteristic. We would expect the transfer of commissioning functions to local authorities to have a positive impact for older peoples and children's services given the removal of organisational barriers between social care and health.</p>	<p>organisational restructuring.</p> <p>There is a risk that the needs of older people will be overlooked given the radical changes from PCTs acting as commissioners to local authorities taking on this additional responsibility.</p>	<p>redundancies in line with employment legislation to ensure a particular age group is not disproportionately impacted.</p> <p>Research by the Nuffield Trust^{xxvi} showed that in a typical locality, 90% of social care users over the age of 55 had been in contact with secondary care during a three year period. Local Authorities are already experienced in commissioning services for older people and there are opportunities for a better aligned system. In addition, under the current system, service users are more likely to be familiar with their local hospital or local authority. Member of the public are less likely to have direct contact with the commissioning arm of the primary care trust.</p> <p>In addition, the NHS information revolution will ensure that comprehensive and accessible data and information will be available to patients, to enable them to make more informed choices about their healthcare and healthy living.</p> <p>Staff will need to have appropriate training to understand the implications of the provisions on Age within the Equality Act 2010 (to come into force from 2012) which will introduce a ban on age discrimination in services and</p>
			<p>There is evidence to suggest that in some circumstances, GPs or other professionals are slower to refer older people for investigation or treatment. There is therefore a risk that some older people may not have the opportunities to</p>	

Protected characteristics	Potential impact	Opportunity to advance equality	Potential negative impacts of the policy	Identify potential or actual adverse impacts and mitigation
Socio-economic deprivation	Positive	Given the strong focus and commitment to tackling inequalities, in particular through the planned allocation methodology for the ring fenced budget . The details are to be developed but a key criterion will be that they reflect socio-economic need and deprivation.	There is a risk that initiatives will benefit the better off in society, those who are more articulate and better able to understand information	There is a clear commitment from the DH to ensure that the initiatives have the greatest potential impact. Local authorities will be held to account on the services they provide. public functions. This will impact on the entire health and social care system.
Marriage and civil partnership	Neutral	The creation of public health england is unlikely to have a significant impact on equality issues relating to marriage and civil partnership. We do however recognise that there is evidence to suggest that there are health benefits when people are in long-term relationships.		

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^{xxiii} Department for Communities and Local Government: London, 'Duty to promote democracy: Equality impact assessment (August 2009)

^{xxiv} Department for Communities and Local Government: London, 'Duty to promote democracy: Equality impact assessment (August 2009)

^{xxv} Banton and Johnson, 'Alcohol Issues and the South Asian and African Caribbean Communities: improving education, research and service development. November 2006.

^{xxvi} The Nuffield Trust, 'Predictive Risk: The Way Forward', Martin Bardsley, Head of Research speaking at the PRIMIS+ Annual Conference (22 September 2010).

Annex F1: Evidence base for Public health EIA

Introduction

In considering the policy options presented in this assessment we have taken into account the existing evidence base on public health and health inequalities demonstrating an understanding of some of the broader equalities issues that need to be considered. We recognise that there are gaps in the evidence relating to specific public health service policy development.

The premise of the public health service will be ***to protect the public; and to improve the healthy life expectancy of the population, improving the health of the poorest, fastest.*** We know that compared to other countries, there are significant areas for improvement within the current system. For example, rates of mortality amenable to healthcare^{xxvii} rates of mortality from some respiratory diseases and some cancers^{xxviii}, and some measures of stroke^{xxix} have been amongst the worst in the developed world^{xxx}. In part, this is due to differences in underlying risk factors, which is why we need to re-focus on public health. However, international evidence also shows we have much further to go on managing care more effectively. For example, the NHS has high rates of acute complications of diabetes and avoidable asthma admissions^{xxxi}; the incidence of MRSA infection has been worse than the European average^{xxxii}, and venous thromboembolism causes 25,000 avoidable deaths each year^{xxxiii}.

Organisational form

The Centre for Health Economics, University of York suggested that “organisational barriers have potentially become more significant recently due to the proliferation of different types of services, governed by different health professionals all of who have their own idea of an ‘ideal user’. Navigation of an entry point into such services may therefore be more difficult for those from disadvantaged groups.^{xxxiv} The transfer of Directors of Public Health to local authorities presents the opportunity to better align health with social care. The Department of Health’s Integrated Care Pilot programme is exploring different ways of delivering more patient-centred and joined up services. A progress report is expected in November 2010, which will provide some early findings from the pilots, which may support the transition process to the public health service.

Joint Strategic Needs Assessment (JSNA)

Race for Health and Shared Intelligence were commissioned by the Department of Health to prepare a report exploring approaches taken by Joint Strategic Needs Assessments (JSNAs) to understand race equality in health and healthcare.

Race equality is beginning to be recognised and addressed within the JSNA. A majority of JSNAs had moved beyond the core dataset and were presenting locally unique and relevant data. Flowing from the presentation of data, some JSNAs understood and were exploring needs relevant to race equality, using community engagement to enhance the professional evidence-base. However, the report found that there was scope for improvement. The study found that although there was no particular model or approach that would produce the most culturally responsive JSNA there were a number of actions that could improve JSNAs^{xxxv}

Race equality was far less prominent an issue in JSNAs compared to socio-economic inequalities. It was felt that there could be a stronger connection between ethnicity and deprivation and the opportunity to link needs assessments with local authority and health organisation equality strategies was sometimes missed. The study also found that the composition of the community and the level of diversity present had no significant impact on the extent to which JSNAs addressed race equality issues. It was recognised that the transition to the new system could provide an opportunity to consider the messages identified within the report.

Marmot Review

In February 2010, the Marmot Review team published 'Fair Society, Healthy Lives'^{xxxvi} based on a year long independent review into health inequalities in England led by Sir Michael Marmot. The review found:

- Reducing health inequalities is a matter of fairness and social justice. In England, there may be people who are currently dying prematurely each year as a result of health inequalities who would otherwise have enjoyed, in total, between 1.3 and 2.5 million extra years of life.
- There is a social gradient in health – the lower a person's social position, the worse his or her health. Action should focus on reducing the gradient in health.
- Health inequalities result from social inequalities. Action on health inequalities requires action across all the social determinants of health.
- Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently.
- Effective local delivery requires effective participatory decision-making at local level. This can only happen by empowering individuals and local communities.

With particular regard to inequalities, Marmot found that "social inequalities exist across a wide range of domains: age, gender, race, ethnicity, religion, language, physical and mental health and sexual orientation... These inequalities interact in complex ways with socio-economic position in shaping people's health status." Given the finding of a 'social gradient' in health. It is important for policy makers at a national and local level to give due consideration to tackling the root causes of inequality.

Engagement with public health professionals

On 16 September 2010, the UK Faculty of Public Health (FPH) published results^{xxxvii} of a survey sent to 3,300 public health specialist members (of which 1,160 members responded) asking for feedback in response to the White Paper, *Equity and Excellence: Liberating the NHS*. There were two questions directly relevant to equality issues. 91.3% agreed that the emphasis on the equity of outcomes is welcomed by the FPH. The majority of surveyed members (59.1%) expressed neutral views about whether the introduction of a new health premium would promote action on reducing inequalities. However, there were more positive responses than negative. (29.5% compared to 11.4%). Overall, members did not feel able to assess (53.3%) at that time whether they believed the White Paper proposals would lead to an improvement in the health of the population of England. The questions directly related to equality issues are outlined below:

	The emphasis on the equity of outcomes is welcomed by FPH and the public health community.	The introduction of a new health premium will promote action on reducing inequalities.
Strongly agree	41.2%	4.5%
Agree	50.1%	25.0%
Neither agree nor disagree	6.9%	59.1%
Disagree	1.4%	9.5%
Strongly disagree	0.4%	1.9%

Employment Legislation

The process of transferring staff where appropriate will be underpinned by due regard to employment legislation in relation to discrimination and the Transfer of Undertakings (Protection of Employment) Regulations (TUPE). In those cases TUPE protects employees' terms and conditions of employment when a business is transferred from one owner to another. Employees of the previous owner when the

business changes hands automatically become employees of the new employer on the same terms and conditions, as though their employment contracts had originally been made with the new employer. Their continuity of service and any other rights are all preserved. Both old and new employers are required to inform and consult employees affected directly or indirectly by the transfer.

Protected Characteristics

The following sections identify points to consider with regard to equality and human rights in access to services, experience and outcomes. This highlights some of the challenges facing the new public health service and underlines why there is a need for a renewed focus on public health.

Age

A wide range of services will be needed by people depending on their age. The proposal to transfer Directors of Public Health from PCTs to Local Authorities will help to ensure close links with other services such as social care, that support older people. Improvements in healthcare, quality of life and lifestyle mean we are all living longer. There will be a substantial increase in the number of people requiring care and support over the coming years. The Government expects the number of disabled younger adults and older people with potential care needs to rise from under 6 million now to around 7.66 million in 2030, an increase of around 1.7 million over 20 years.^{xxxviii}

Our population is ageing rapidly. By 2024, an estimated 50% of the population will be over the age of 50, due to a combination of increased life expectancy and low birth rates. Many people over 65 are also carers. Many risk factors for poor health, such as obesity, hypertension, disability and poverty increase with age:

- The prevalence of most acute and chronic diseases increases with age including cancer, cardiovascular disease, diabetes, suicide, and dementia. Older people also often suffer co-morbidities.
- The proportion of people with a long term illness or disability that restricts their daily activities increases with age. About 3.5 million people aged 65+ have a limiting longstanding illness or disability.
- Older people over 75 account for the largest proportion of deaths from accidents.^{xxxix}

Dementia affects 750,000 people in the UK. Numbers are expected to double by 2030. The annual costs of dementia in the UK amount to £17 billion. Around 50% of dementias have a vascular component, which is associated with diet and lifestyle. There are increasing numbers of frail older people. In winter 2008-09, there were 35,000 excess deaths in England. Many of these deaths could have been prevented and are associated with cold household temperatures.

There is also evidence to suggest that in some circumstances the age of a patient may influence a GPs decision to refer a patient to specialised treatment. For example, A study of electronic patient records by the Brighton and Sussex Medical School suggests that older women with suspected ovarian cancer may be referred later for investigation than younger women^{xl}. Between 2002-06, 82% of women under the age of fifty-five years had received at least one relevant investigation in the year before their diagnosis; this figure fell to 75% for women aged between fifty-five and sixty-nine years, and 66% for women aged over seventy years. GPs were also found to be slower to refer elderly patients than their middle-aged counterparts. Women aged between forty-five and sixty-nine years tended to be referred for gynaecological investigation within ten weeks of presenting to their GP with their first symptom. This figure steadily increases, peaking at twenty weeks for women aged seventy-five to seventy-nine years. From 2012, the provision within the Equality Act 2010 will introduce a ban on age discrimination in services and public functions. This will impact on the entire health and social care system. Banning age discrimination could lead to 'Active Ageing' - when health, labour market, employment, education and social policies support active ageing there will potentially be:

- fewer premature deaths in the highly productive stages of life
- fewer disabilities associated with chronic diseases in older age
- more people enjoying a positive quality of life as they grow older
- more people participating actively as they age in the social, cultural, economic and political aspects of society, in paid and unpaid roles and in domestic, family and community life
- lower costs related to medical treatment and care services^{xli}.

Disability

Disability affects the length and quality of life, and can adversely affect access to services. There is heterogeneity amongst disabled people arising both from variations in impairment and from variations in socio-demographic characteristics. It is estimated that approximately 20% people within the United Kingdom have an impairment this percentage increases to 47% when focussing on those over the state pension age.^{xlii} According to the 2001 Census, 18% of people reported a long-term illness or impairment that restricted their daily activities.

There is evidence that disabled people experience unequal access to health services and inequalities in health. Particular barriers can be demonstrated for some specific groups especially people with learning disabilities or long-term mental health conditions who experience poorer health outcomes and shorter life expectancy. For example, the Disability Rights Commission 2006 Report *Closing the Gap* highlighted high incidence of obesity and respiratory disease in people with learning disabilities and obesity, smoking, high blood pressure, respiratory disease and stroke among people with long-term mental health conditions. It was also found that four times as many people with learning disabilities die of preventable causes as people in the general population.

Evidence has also identified that people with learning disabilities experience both worse access to general health services as well as worse health outcomes than the general population for a variety of diseases and conditions, such as respiratory disease, heart disease, mental ill health, hearing and visual impairments and osteoporosis. Epilepsy is over 20 times more common in people with learning disabilities than in the general population. Sudden unexplained death in epilepsy is five times more common in people with learning disabilities than in others with epilepsy.^{xliii}

Mental ill health is linked to increase mortality from cardiovascular disease, cancer, respiratory disease, metabolic disease, nervous system diseases, accidental death and mental disorders^{xliv}. Another risk factor is the fact that poor mental health is associated with poor compliance with treatment for health problems^{xlv}

Carers

Carers provide unpaid care and support to ill, frail or disabled friends or family members. People from all walks of life and backgrounds are carers - over 3 in 5 people in the UK will become carers at some time in their lives. Caring can be a rewarding experience, yet many face isolation, poverty, discrimination and ill-health^{xlvi}. Carers UK^{xlvii} suggest that not all carers experience poor health as a result of ill health but this is dependent on a number of factors:

- lack of appropriate information
- lack of appropriate support
- isolation
- financial stress

The Carers Strategy (2008)^{xlviii} found that cultural concepts of caring are not universally shared throughout communities in Britain; many people from other countries do not have experience of a welfare state and therefore, among a whole range of concepts, would not understand the concept of a 'carer'.⁵ The National Black Carers and Carers Workers Network have highlighted that they have been unable to find a word in Gujarati, Urdu, Punjabi or Bengali which translates into 'carer';

We know that Women were more likely to be carers than men, 18 per cent compared with 14 per cent. There were no gender differences in the proportion caring for someone in the same household but women were more likely than men to look after someone outside the household, 12 per cent compared with 9 per cent. Women also predominated in the sub-groups with the heaviest commitments: 11 per cent of women compared with 7 per cent of men were main carers and 5 per cent of women compared with 3 per cent of men spent 20 hours a week or more on caring tasks^{xlix}. In addition, Bangladeshi and Pakistani groups are more likely to be carers than any other ethnic group^l.

From October 2010, Carers have legislated protection under the Equality Act 2010 (discrimination by association).

Race

The Afiya Trust in 'Achieving Equality in Health and Social Care *Spring 2010*' suggests that "Many minority ethnic communities have poor access to health and social care services for a variety of reasons including language barriers, lack of awareness/information, social isolation, lack of culturally sensitive services and negative attitudes about communities"^{li} This is also echoed by Goddard who suggests that perceptions of cultural sensitivity of services has been reported as an important influence on both entering into the health care system and maintaining contact. Barriers to help-seeking include perception of language difficulties, lack of awareness about beliefs and values and lack of translation facilities.^{lii}

BME communities can be affected disproportionately by the biggest causes of poor health (musculoskeletal conditions, heart disease, stroke, diabetes, respiratory diseases, anxiety, depression and dementia. *The Health of Minority Ethnic Groups Health Survey for England (2004)*^{liii} found that:

- the prevalence of diabetes among South Asians can be up to five times that of the general population;
- rates of diabetes among Black Caribbean's are also higher than the general population;
- South Asians experience significantly higher rates of coronary heart disease;
- there is also evidence of higher rates of heart disease amongst Irish men and women;
- incidence of first-time stroke is twice as high among African Caribbean people as it is among Europeans;
- African and South Asian people are also at higher risk of stroke.

'No Patient Left Behind' outlined some of the key issues preventing certain BME groups obtaining equal access to primary care services, including dysfunctional communication between healthcare organisations and patients and poor NHS links with local communities.^{liv} To take forward the recommendations within this report, the Department of Health set up a GP Access Programme that works to improve practice in five high impact areas: monitoring ethnicity, training, improving communication, having a reflective workforce and better engagement with BME patients. Positive outcomes from this work included 'Improving the patient experience', a training DVD/online resource for practices endorsed by the chairmen of the Royal College of General Practitioners and British Medical Association.^{lv}

Our findings confirm and extend the practice-based evidence on poorer health in Gypsy Traveller populations. There is now little doubt that health inequality between the observed Gypsy Traveller

population in England and their non-Gypsy counterparts is striking, even when compared with other socially deprived or excluded groups and with other ethnic minorities.

The evidence base on travellers (variously described as gypsies, Romanies or the Roma people) have poorer health status than non-travellers, but reliable evidence on the health of adults is sparse. A team of health services researchers from the University of Sheffield, aided by gypsy travellers and health service staff, conducted a large-scale epidemiological study using standard health measures, supplemented by in-depth interviews to explore health experiences, beliefs and attitudes. Significant health inequalities were found and the study suggested that “Barriers to health care access were experienced, with several contributory causes, including reluctance of GPs to register Travellers or visit sites, practical problems of access whilst travelling, mismatch of expectations between Travellers and health staff, and attitudinal barriers. However, there were also positive experiences of those GPs and health visitors who were perceived to be culturally well-informed and sympathetic, and such professionals were highly valued.

Religion and Belief

There are a wide range of religions and beliefs practiced in the UK today. We need to be aware of and sensitive to how these impact on and influence attitudes to planning, giving and receiving healthcare from pre-conception through to dying and even after death. It should never be assumed, however, that an individual belonging to a specific religion or belief system will necessarily comply with or fully observe all the practices and traditions of that religion or belief system. For this reason, each person should be treated as an individual, and those treating them should try to ascertain their views and preferences before treatment begins.^{lvi} For example, whilst specific religions or beliefs may forbid the use of alcohol, this does not infer that people adopting that religion or belief will not need to access substance misuse services but there may be stigma and fear of accessing such services. Cultural beliefs within communities may also be a barrier for accessing services. Banton and Johnson^{lvii} suggest that “Time and time again alcohol use, especially problematic use, is viewed as something that should not be disclosed to others within and outside the South Asian and African Caribbean communities”.

Sexual Orientation

21 Lesbian, gay, bisexual and trans (LGBT) people experience a number of health inequalities which are often unrecognised in health and social care settings. Research suggests that discrimination has a negative impact on the health of LGBT people in terms of lifestyles, mental health and other risks. Many people are reluctant to disclose their sexual orientation to their healthcare worker because they fear discrimination or poor treatment.^{lviii} LGBT people have higher levels of alcohol consumption, are more likely to smoke and more likely to misuse drugs than heterosexual people. Although there has been some controversy about these assumptions, researchers have pointed to the lack of social spaces for LGBT people apart from pubs and clubs. They suggest that LGBT people have been obliged to use the ‘scene’ and to fit in with a drinking culture. There is also an association between harassment in the workplace and alcohol problems for lesbian and bisexual women in comparison with heterosexual women.^{lix}

Gender

There is significant variation in health outcomes. In males, life expectancy in urban areas ranged from 72.3 years in the most deprived quintile to 80.3 years in the least deprived, compared with 73.5 years and 79.9 years respectively in rural areas. The variations were much smaller in females, with life expectancy ranging from 78.1 years to 83.6 years in the most deprived to the least deprived urban areas and from 78.4 years to 83.3 years respectively in rural areas. The figures show that inequalities were widest among men in urban areas (8.0 years)^{lxi}. Although women live longer than men, they also spend more years in poorer health.

Research indicates that the gender of the practitioner can impact on people's willingness to use services, e.g. improved attendance rates for cervical cancer screening in practices with female practitioners or men indicating a preference for male practitioners for certain procedures and health problems. It has also been argued that although gender sensitive delivery of care is relevant in some cases, the ability of health professionals to attend to of the individual in a sensitive and understanding manner is equally important.^{lxii}

The Men's Health Forum^{lxiii} found that Men are much less likely to visit their GP than women. Under the age of 45, men visit their GP only half as often as women. It is only in the elderly that the gap narrows significantly and even then women see their GP measurably more frequently than men. A survey of men conducted by the Men's Health Forum suggested that many men are unhappy with the service provided at their local GP surgery for reasons that are rectifiable: unhelpful opening hours; perceived emphasis on services for women and children; and undue bureaucracy.

Pregnancy and Maternity

A key area of health and care for women is pregnancy and maternity. Apart from a slight drop in live births in the early part of the decade, the number of births has been rising steadily. This increase in numbers has also been accompanied by an increase in the rate of births (more live births per 100,000 population) compared to 1 or 5 years previously.

There has been substantial progress in reducing infant deaths, which is a good proxy for maternal health in general. The infant mortality rate in 2009 was the lowest ever recorded in England and Wales, with fewer than 5 deaths per 1000 live births in the UK (around 3300 deaths in total) compared to 22 deaths per live birth in 1960s¹²¹. Whilst relatively few children die in infancy, these rates are higher than in comparable European countries and infant mortality is a key indicator of wider health inequalities. There is a 70% gap in infant mortality between managerial and professional groups and routine and manual groups, and rates for some ethnic groups are almost twice the national average.

The overall rate of teenage conceptions has decreased for both under 16s and under 18s, and the under 18s conception rate is now the lowest it has been for 20 years. Despite this, the percentage of all live births to mothers under age 20 in the United Kingdom remains the highest when compared to other EU-15¹²² countries.^{lxiv}

There is evidence that certain groups of young people seem to be vulnerable to becoming teenage parents^{lxv} including:

- Young people in or leaving care
- Homeless young people
- School excludees, truants and young people under-performing at school
- Children of teenage mothers
- Members of some ethnic minority groups for example, Caribbean, Pakistani and Bangladeshi women are more likely than white women to have been teenage mothers
- Young people involved in crime

The Equality Act 2010 extends protections across pregnancy and maternity. The health and wellbeing of women before, during and after pregnancy is important factor in giving children a healthy start in life and laying the groundwork for good health and wellbeing in later life. Good quality antenatal care is important for good outcomes. However, many women simply do not access or keep in touch with antenatal services, because of issues such as domestic violence, teenage pregnancy or not having English as a first language^{lxvi}.

¹²¹ Ref ONS

¹²² Member states that were part of the European Union prior to expansion in 2004.

Socio-economic status has a significant impact on health inequalities amongst children. N J Spencer^{lxvii} suggests that children born to lower socio-economic groups are more likely to be of low birth weight, die in the first year of life and to suffer significant episodes or morbidity. In addition, young women living in socially disadvantaged areas are less likely to opt for an abortion if they get pregnant^{lxviii}

Transgender

Under the new Equality Act 2010¹²³, trans people who have changed their sex, are in the process of changing their sex or have informed someone that they are planning to change their sex, are given additional protection against discrimination. In addition, trans people will no longer have to be under medical supervision to be protected from discrimination and harassment.^{lxix}

The term 'transgender' is used to describe people who have a strong belief that they properly belong to their non-biological gender. Often 'transgender' and 'trans' are used interchangeably. Data and research on trans health are limited but the evidence base is growing. We know that trans people are particularly vulnerable to discrimination and harassment, and also experience inequalities in access to healthcare and health outcomes.

The funding of gender identity services are currently the responsibility of Primary Care Trusts and it is proposed that specialist commissioning including gender identity services will lie with the NHS Commissioning Board. However, it is important for organisations delivering public health services to be aware of the potential discrimination that transgender people may experience. Assess to appropriate services can be difficult. Trans service users are at risk of being excluded from screening programmes (cervical, breast, prostate) or do not receive information about important general health and wellbeing issues because of the preconceptions of health care staff.^{lxx}

Inequalities by socio-economic group

As outlined by the Marmot review, there are significant socio-economic inequalities which impact upon health outcomes.. Harm from alcohol, illicit drugs, and smoking is concentrated in people from lower socio-economic groups; 30% of males and 20% of females in the most disadvantaged groups have at least two or three high risk behaviours compared with less than 10% and less than 5% respectively in the least disadvantaged groups. The most deprived fifth of the population experience 2 to 3 times greater loss of life due to alcohol (although people drinking more than the NHS guidelines are present throughout society)^{lxxi}. Problem drug users also tend to be concentrated in the poorest communities and evidence puts their rates of premature death at between 12 and 17 times greater than the non drug using population.^{lxxii lxxiii lxxiv lxxv}

¹²³ This aspect of the Equality Act 2010 came into force in October 2010.

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Equality Impact Assessment

Annex G: Overarching Evidence Base for Equality Impact Assessments

Race

- G1. The UK is becoming increasingly ethnically diverse. The 2001 Census showed that approximately 12.7% of the population of England and Wales was from a black and minority ethnic (BME) background. Population projections indicate that this percentage increased to 15.7% in 2007 and will increase further to 21.2% by 2016. In 2026, it is estimated that the total BME population will rise to 28.4%. The younger age profile of BME communities, higher fertility rates among females resident within England and Wales but born outside the UK, and inward migration are all contributing factors to this predicted BME population increase. Due to higher levels of migration between the late 1940s and 1960s, there will be a significant increase in the numbers of BME older people across the next two decades, particularly among African Caribbean and South Asian communities.⁷⁶
- G2. Risk factors and disease patterns vary between ethnic groups, for example:
- South Asians, particularly Bangladeshis and Pakistanis, have significantly higher ischaemic⁷⁷ heart disease (IHD) prevalence and mortality than the general population.⁷⁸
 - Although people of African-Caribbean descent have a low prevalence of IHD compared with the white population, they have much higher prevalence of and mortality from hypertension and stroke.⁷⁹
 - South Asians (particularly Pakistanis and Bangladeshis) and African-Caribbeans have a three to six-fold higher prevalence of Type 2 diabetes than the general population.⁸⁰
 - Breast cancer incidence is generally lower amongst BME groups than amongst white British women. However, Black women aged 15-64 years had significantly poorer survival from breast cancer at both one and three years than White women (85% compared with 91% at three years).⁸¹
 - After adjusting for age, Bangladeshi and Pakistani men and women and Black Caribbean women were more likely to report bad or very bad health than the general population.⁸²

Gypsies and Travellers

While there is no accepted definition, gypsies and travellers are generally taken to mean all persons with a cultural tradition of nomadism or of living in a caravan and all other persons of a nomadic lifestyle, whatever their race or origin. Romany Gypsies and Irish Travellers are recognised as ethnic groupings under the Race Relations Act 1976 and make up 0.6% of the total UK population.

Key health issues for Gypsies and Travellers include mental health problems, diabetes, respiratory problems, maternal & child health and long term illness. A study of Irish Travellers in Ireland reported that women lived 12 years less than women in the general population and men 10 years less. Prevalence of miscarriages, stillbirths and neonatal deaths are higher than average, and there are also high rates of maternal

death during and shortly after pregnancy.

Common problems of primary care access for Gypsies and Travellers is registering at a GP practice, as staff often insist on being given a permanent address. This can lead to increased reliance on A&E and walk-in centres; presenting with multiple conditions and receiving poorer follow up, due to nomadic lifestyle or frequent eviction from traveller sites.⁸³

- G3. An analysis of the 2009/10 GP Patient Survey carried out by Ipsos MORI contains an extremely useful disaggregated data that highlights areas of significant difference in the responses of key equality groups.⁸⁴
- G4. The results show that Pakistani and Bangladeshi service users most frequently felt that they received a poorer service from their GP surgery than other ethnic groups in a range of areas. For example, Pakistani, Bangladeshi patients were felt less able to obtain an appointment with a doctor within 2 days or a practice nurse, and saw their preferred doctor less frequently. Regarding communication with their doctor or practice nurse, Chinese patients often reported the lowest satisfaction, followed by Bangladeshi and Pakistani patients. Chinese patients often felt that the doctor or practice nurse did not give them enough time as other patients, took their problems less seriously and did not adequately involve them in discussions regarding their health, wellbeing and treatment. They were also the least satisfied with the opening hours of their practice than other groups.
- G5. When looking at the overall satisfaction with care received, Chinese and Bangladeshi patients were the least satisfied (28%), followed by Pakistani patients (29%). The most satisfied groups were White Irish (61%) and White British patients (58%). Only 46% of Chinese patients expressed having confidence in their doctor, considerably lower than any other ethnic group; the second lowest response was from Bangladeshi patients (54%). Most satisfied were White Irish and White British patients (73% and 72% respectively).
- G6. 'No Patient Left Behind' outlined some of the key issues preventing certain BME groups obtaining equal access to primary care services, including dysfunctional communication between healthcare organisations and patients and poor NHS links with local communities.⁸⁵ To take forward the recommendations within this report, the Department of Health set up a GP Access Programme that works to improve practice in five high impact areas: monitoring ethnicity, training, improving communication, having a reflective workforce and better engagement with BME patients. Positive outcomes from this work included 'Improving the patient experience', a training DVD/online resource for practices endorsed by the chairmen of the Royal College of General Practitioners and British Medical Association.⁸⁶
- G7. In a report examining equality of access to services⁸⁷, the authors highlighted a number of barriers faced by BME communities:
- **Language:** Availability to translation and interpreting services remains a key issue, especially when accessing out of hours services. However, simply providing these services does not address other barriers to access, such as fear of confidentiality.

- **Knowledge:** Newly arrived communities can experience difficulty in navigating the UK health service. In countries with less developed primary care, health services are often accessed via the nearest hospital. There is also poorer utilization of specialist outpatient and inpatient care among BME communities. This barrier is linked to issues regarding language. A study of migrants from central and eastern Europe found that those who were most fluent in English had a greater knowledge of the services available to them.
- **Cultural Awareness:** Studies have revealed a lack of knowledge among healthcare professionals about the cultural practices of different ethnic communities, however there is some evidence that this may be improving.

- G8. There are certain areas of care where ethnic inequalities remain entrenched. 'Count Me In 2009', the fifth national census of in-patients in mental health and learning disability services found that 22% were from minority ethnic groups – double the percentage within the national population at the 2001 Census, although we know that there have been demographic changes since that time. Black Caribbean, Black African, Other Black, White/Black Caribbean Mixed and White/Black African Mixed patients continue to experience rates of admission that are three times higher than average. Among 'Other Black' groups, this rises to nine times the average admission rate. For other ethnic groups, rates were average or below average. Median lengths of stay were the longest for people from Black Caribbean and White/Black Caribbean Mixed groups.
- G9. Across all five censuses, rates of detention under the Mental Health Act were consistently higher for Black Caribbean and Other Black groups. There is also evidence that some BME groups are less likely to be referred to primary and secondary psychological (talking) therapies. The impact of delayed access to timely and appropriate services is that service users are more likely to be at a crisis point when entering services rather than accessing through a managed care pathway.
- G10. Recent analysis of data from the 1998, 1999, 2003 and 2004 Health Survey for England suggests that inequalities in access to primary care services may be reducing. Nazroo et al (2009) found that respondents from minority ethnic communities were not less likely to use GP services and no inequalities in clinical outcomes of care for hypertension and raised cholesterol (outcome of care for diabetes were mixed). However, disparities still exist in access to hospital services, and marked inequalities in use of dental services.⁸⁸

Asylum seekers and refugees

Article 3 of the European Convention on Human Rights states that 'No one shall be subjected to torture or inhuman or degrading treatment or punishment'. Article 31 of the 1951 Refugee Convention prohibits states from penalising a refugee for illegal entry when the purpose of their entry is to claim asylum. An asylum seeker is someone who has lodged an application for protection on the basis of the Refugee Convention or Article 3 of the ECHR. Refugee status is awarded to someone the UK recognises as a refugee as described in the Refugee Convention.⁸⁹ Recent statistics (Quarter 2, 2010) show that 5,220 initial asylum decisions were made, an decrease of 8 per cent for the same period in 2009. 76 per cent of initial decisions were refusals, 15 per cent were grants of asylum and 9 per cent were grants of Humanitarian Protection or Discretionary Leave.⁹⁰

Health studies have shown that refugees and asylum seekers often have poorer health outcomes; one in six refugees has a physical health problem and two thirds have experienced anxiety or depression. Basic health needs for these groups may be broadly similar, however previous poor access to health care may mean that many health conditions have been left untreated. Screening and preventive measures may also be new concepts to asylum seekers from less developed countries. Language can be a major barrier to accessing healthcare and reporting health problems. Although the health outcomes for refused asylum seekers is similar to refugees, there is an increasing body of evidence that shows their health deteriorates rapidly. As refused asylum seekers cannot claim most benefits and have limited access to free healthcare, the burden of care often falls on refugee communities, faith communities and voluntary sector organisations.^{91 92 93}

Disability

- G11. Disability affects the length and quality of life, and can adversely affect access to services. There is heterogeneity amongst disabled people arising both from variations in impairment and from variations in socio-demographic characteristics. It is estimated that approximately 20% people within the United Kingdom have a disability; this percentage increases to 47% when focussing on those over the state pension age.⁹⁴ According to the 2001 Census, 18% of people reported a long-term illness or disability that restricted their daily activities.
- G12. Although there is a lack of routine data measuring health outcomes for disabled people, research shows that disabled people generally fare less well than non-disabled people do across a wide range of indicators and opportunities. A report commissioned by the Office for Disability Issues found that younger disabled people, people who had disabled all their lives, disabled people with mental health difficulties, disabled people in lower socio-economic groups or with lower incomes and disabled people from minority ethnic communities all were less likely to feel positive about their lives than the average disabled respondent.⁹⁵
- G13. When considering primary care services, the picture is mixed. The 2009/10 GP Patient Survey shows that people with long term illnesses have more confidence and trust in their doctor (72% and report greater satisfaction levels (59%) than the general population (70% and 55% respectively). Also, 65% of people with long term illnesses would recommend their surgery to people moving into the area, compared to 62% generally. However, when looking specifically at deaf people and British Sign Language users, 62% expressed having confidence and trust in their GP and only 49% would recommend their surgery to other newly arrived residents.⁹⁶

Learning disabilities

The spectrum of learning disabilities is wide ranging. Officially, people with learning disabilities are defined as having:

- A significantly reduced ability to understand new or complex information and/or learn

new skills (impaired intelligence)

- A reduced ability to cope independently (impaired social functioning which started before adulthood, with a lasting effect on development)⁹⁷

These impairments make it harder for people with learning disabilities to read, write and understand verbal instructions. It is estimated that there are approximately 828,000 people over 18 years with a learning disability in England, 22% of whom are known users of disability services.⁹⁸ The Care Quality Commission's 'Count Me In' census conducted in 2009 reports that 13% of learning disability patients were from BME groups, compared to 8% in the population as a whole.

People with learning disabilities (PWLD) experience worse health outcomes than the general population for a variety of diseases and conditions, such as respiratory disease, heart disease, mental ill health, hearing and visual impairments and osteoporosis. Epilepsy is over 20 times more common in PWLD than in the general population. Sudden unexplained death in epilepsy is five times more common in people with learning disabilities than in others with epilepsy.⁹⁹

Entrenched inequalities exist in access to health services as highlighted in Mencap's 2007 report, 'Death By Indifference', where a lack of adequate or appropriate access to services resulted in the deaths of six people with learning difficulties.¹⁰⁰ The 2008 'Healthcare for All' inquiry, commissioned by the Department of Health in response to the Mencap report, suggested that "an annual health check; support when a visit to hospital is needed; help to communicate; better information, and tighter inspection and regulation will all work to reduce inequalities in access to and outcomes from healthcare services".¹⁰¹

Carers

G14. When considering the health and well being of disabled people and people with long term conditions, the health and wellbeing of carers is also important. From the 2001 Census, we know that there are approximately 5.2 million carers in England and Wales, a million of which provide care for 50 or more hours a week. More than half of those providing 50+ hours care are over 50 years old and almost a quarter declare themselves as being in 'not good health'. There are also a significant number of people caring for people who themselves require support or care – around 273,000 people with long term conditions or disabilities are caring for others, with 105,000 of this number providing 50 or more hours of care. Women are more likely to be carers than men.¹⁰² It is estimated that the economic value of the contribution made by carers is £87 billion.¹⁰³

G15. Carers UK carried out a Carers, Employment and Services (CES) study in 2006-07 which involved surveying almost 2000 carers nationally, including conducting 134 face to face in depth interviews. This study resulted in a series of reports looking at the experiences and needs of particular groups of carers. 'Diversity in caring: towards equality for carers' was the third report and included a focus on ethnic minority carers. The report found that non-White carers were more likely to be struggling financially compared to their White counterparts. This may, in part be a result of some minority ethnic groups (particularly Indian, Pakistani and Bangladeshi communities) having a greater proportion of carers of working age and therefore not able to work

or work full time. BME carers were also more likely to be caring for a sick or disable child or someone with a mental health problem.¹⁰⁴

G16. The 2001 Census pointed to a link between the number of hours of care given and poorer self-assessment of health. The CES study also identified an association between length of time as a carer and poorer health. Unemployed carers were also more likely to report poorer health. Carers reporting poorer health were also more dissatisfied with the services that were available to them, citing difficulties in accessing services as a contributory factor.¹⁰⁵

Gender

G17. There are differences in risk factors and health outcomes between men and women. Some are due to biological and physiological differences, but others are not. For example:

- Life expectancy continues to be considerably higher for women (82.02 years) than for men (77.93 years);^{106 107}
- Although women live longer than men, they also spend more years in poorer health;
- Cancer morbidity and mortality rates are higher in men for all non sex specific cancers, but are reducing at a faster rate than for women;
- Men are more likely to drink above recommended limits, smoke and have poorer diets than women, however binge drinking among women is increasing at a faster rate, smoking rates are falling faster among men but have remained relatively stable among women, and women are more likely to become morbidly obese than men
- There is a higher prevalence of mental health problems among women, though suicide mortality rates are considerably higher among men;¹⁰⁸

G18. There have also been positive developments in health and lifestyle. For example:

- The proportion of adults consuming five or more portions of fruit and vegetables a day increased from 2001 for both men and women, to a peak in 2006 and 2007. However, the proportion consuming five or more portions a day was lower in 2008.
- The proportion of males and females who are physically active has risen in the last five years.¹⁰⁹

G19. Perceptions of risk factors between men and women may affect health outcomes. For example, there is evidence that people perceive vascular disease as a problem for men and see men's pattern of symptoms as the norm. This can lead to women presenting later, as their symptoms are not always recognised, leading to late diagnosis and poorer outcomes.¹¹⁰

G20. The GP Survey report highlighted a few areas where there were significant differences between male and female responses. For example, female patients were more likely to say that they preferred to see a particular doctor (66%), compared to 58% of male respondents. Women were also more likely than men to want additional opening time for their surgery (58% and 53% respectively).¹¹¹ The 2008 General Lifestyle Survey (formerly General Household Survey) reported that males had 20% fewer visits to their GP than females. This difference tends to be greatest among the 16 to 44 age group, where women are twice as likely to use GP services than

men for a range of health issues.¹¹² This pattern is also replicated in the use of dental services and seeking advice from community pharmacists.¹¹³

- G21. Research indicates that the gender of the practitioner can impact on people's willingness to use services, e.g. improved attendance rates for cervical cancer screening in practices with female practitioners or men indicating a preference for male practitioners for certain procedures and health problems. It has also been argued that although gender sensitive delivery of care is relevant in some cases, the ability of health professionals to attend to of the individual in a sensitive and understanding manner is equally important.¹¹⁴

Sex workers

Sex work refers to the exchange of sexual services for some form of payment, usually money or drugs. Professionals emphasise the importance of the distinction between street-based and off-street prostitution because of the differing nature of the work, the risks and the needs of the groups involved. It is estimated that there are approximately 80,000 sex workers in the UK. Most are young women aged between 25 and 27 years

Key health risks and well being issues include violence and sexual assault, substance misuse, sexually transmitted infections and mental illness. Street workers, who have the most acute health needs, are more likely to be in contact with health care services than the general population. On average, they reported visiting the GP 8.5 times compared to four times for the population as a whole. They also reported attending A&E 2.5 times more and an outpatient clinic 4.3 times more. Despite this increased use of services, a comparatively low percentage have had routine health checks, such as cervical screening, or attended antenatal checks when pregnant.¹¹⁵

- G22. A key area of health and care for women is pregnancy and maternity. Apart from a slight drop in live births in the early part of the decade, the number of births has been rising steadily. This increase in numbers has also been accompanied by an increase in the rate of births (more live births per 100,000 population) compared to 1 or 5 years previously. The overall rate of teenage conceptions has decreased for both under 16s and under 18s, and the under 18s conception rate is now the lowest it has been for 20 years. Despite this, the percentage of all live births to mothers under age 20 in the United Kingdom remains the highest when compared to other EU-15¹¹⁶ countries.¹¹⁷

- G23. In 2007, the Healthcare Commission (now Care Quality Commission) undertook a survey of women who used maternity services. Some of the key findings were as follows:

- The majority of women saw a health professional when they wanted and had choice about where to have their baby.
- Most respondents (94%) who wanted a screening test to check whether their baby was at increased risk of developing Down's syndrome said they had the test.

- A large percentage (89%) rated the overall care received during labour and birth as "excellent", "very good" or "good" and 82% said they were always spoken to in a way they could understand during this time.

G24. Areas of concern included:

- More than a third (36%) of respondents said they were not offered any antenatal classes provided by the NHS, though the majority of these respondents (76%) were women who had previously given birth.
- During labour a quarter of respondents reported that they had been left alone at a time when it worried them.
- More than a third (37%) felt they had not always been treated with kindness and understanding.¹¹⁸

G25. This survey formed part of a review carried out by the Healthcare Commission in 2008, which gave a number of key recommendations on improving staffing levels and practices, systematically gathering and acting on the views of women using their services, improving IT systems and strengthening the performance monitoring of Trusts, particular regarding the care of women and babies from high risks groups.¹¹⁹

Transgender¹²⁰

G26. The term 'trans' is

"a very broad term to include all sorts of trans people. It includes cross dressers, people who wear a mix of clothing, people with a dual or no gender identity, and transsexual people. It is also used to define a political and social community which is inclusive of transsexual people, transgender people, cross-dressers (transvestites), and other groups of 'gender-variant' people"¹²¹

G27. The term 'transgender' is used to describe people who have a strong belief that they properly belong to their non-biological gender. Often 'transgender' and 'trans' are used interchangeably.

G28. Data and research on trans health are limited but the evidence base is growing. We know that trans people are particularly vulnerable to discrimination and harassment, and also experience inequalities in access to healthcare and health outcomes.

G29. There are two established international systems for classifying mental illnesses: the Diagnostic and Statistical Manual of Mental Disorders (DSM) which includes the term 'gender identity disorder' as a mental health disorder and uses it to describe people who experience significant gender dysphoria, i.e. discontent with the biological sex they are born with. Secondly, the WHO International Statistical Classification of Diseases and Related Health Problems (ICD) lists transsexualism as a mental and behavioural disorder. Transgender people are thus labelled as having a mental disorder. The DSM and ICD systems are used within the UK.

G30. Some trans people argue that being diagnosed stigmatises individuals in society and makes them objects of medicine, rather than subjects who are responsible for expressing their own health needs. However, these approaches are not mutually exclusive and the NHS White Paper vision is

for services that take account of the patient's expression of their own health needs as an intrinsic part of the provision of medical treatment. Particular concerns have been expressed that a mental health diagnosis means losing the right to patient choice. The White Paper introduces choice of treatment and provider in some mental health services. This will begin from April 2011, and will be extended wherever practicable.

- G31. Trans people often complain of severe delays in accessing appropriate reassignment services and treatment. GPs play a crucial first line role for individuals in the process of seeking gender reassignment treatment. A survey found that some respondents reported discriminatory treatment from their GP e.g. 21% of GPs either did not want to help, or in 6% of cases, refused to help.¹²²
- G32. Criticisms have been levelled at a perceived 'one size fits all' approach to gender reassignment. Some researchers argue that only those who articulate the current medical understanding of gender dysphoria are granted gender reassignment, whilst those whose gender identities are more complex or ambiguous are denied treatment. It is suggested that trans people will conform to the medical discourse on transsexualism in order to ensure they receive treatment.^{123,124} Gender reassignment clinicians argue that that this is a misperception and that they are well aware of the huge diversity of presentation, including the most complex, ambiguous presentations of gender identity, and fully agree that a single approach would be ineffective as well as undesirable.
- G33. There are, however, strong differences of opinion between some Gender Identity Clinics and some trans stakeholder groups about access to hormone therapy. It is an international requirement (under version 6 of the World Professional Association for Transgender Health Guidelines) of genital surgery that it must be preceded by a period of living in the acquired gender, or Real Life Experience (RLE). Yet the Harry Benjamin International Gender Dysphoria Association recommends hormones precede RLE. In practice, Gender Identity Clinics are expected to cooperate with the individual to determine the best course of treatment rather than stipulating a rigid period of time before commencing hormone therapy. The White Paper emphasis on shared decision-making further strengthens this approach.
- G34. The funding of gender identity services are currently the responsibility of Primary Care Trusts. Trans people have complained that PCTs are often reluctant to fund gender identity treatment. Decisions are made locally as to what to commission, and can result in considerable variation. The Department of Health does not determine these decisions, which are a matter for local prioritisation and decision-making. However, under the NHS White paper, the NHS Commissioning Board will have responsibility for commissioning specialised services, which will include gender identity services.
- G35. Accessing appropriate care for other health conditions can be problematic, in terms of both the services offered and the attitudes that trans people encounter. Trans service users are at risk of being excluded from potentially life-saving cancer screening programmes (cervical, breast, prostate) or are not given information about important general health and well-being issues because of the preconceptions of healthcare staff.¹²⁵
- G36. Under the new Equality Act 2010¹²⁶, trans people who have changed their sex, are in the process of changing their sex or have informed someone that they are planning to change their sex, are

given additional protection against discrimination. In addition, trans people will no longer have to be under medical supervision to be protected from discrimination and harassment.¹²⁷

Age

- G37. Children and young people under 16 years of age comprise just over 20% of the national population.¹²⁸
- G38. Many of the health inequalities faced by children are directly linked to poverty. For example, children and young people from poorer backgrounds are more likely to become obese, suffer from dental caries and develop mental and emotional health difficulties. They are also more likely to grow up in a household exposed to tobacco smoke and to begin smoking at a young age. Young people from deprived backgrounds are also more likely to become teenage parents, and children of these parents tend to have poorer health outcomes.¹²⁹
- G39. The infant mortality rate has fallen steadily over the ten years to 2008, and is now at its lowest ever level. Despite this decrease, rates are higher in England than the EU-15 average.^{130 131}
- G40. We know that there are particular groups of children and young people who experience considerable inequalities in outcomes and access to services, such as children in care, children with learning disabilities, young refugees or asylum seekers and children from some minority ethnic communities. An example of this is access to appropriate mental health services; a recent interim report from the national CAMHS¹³² review stated that ensuring vulnerable children have swift and easy access to appropriate services remained a key challenge.^{133 134}
- G41. People aged 65 years and older account for 16% of the national population¹³⁵. By 2024, this is likely to increase to 40%.
- G42. Many risk factors for poor health, such as obesity, hypertension, disability and poverty increase with age:
- The prevalence of most acute and chronic diseases increases with age including cancer, cardiovascular disease, diabetes, suicide, and dementia. Older people also often suffer co-morbidities.
 - The proportion of people with a long term illness or disability that restricts their daily activities increases with age. About 3.5 million people aged 65+ have a limiting longstanding illness or disability.
 - Older people over 75 account for the largest proportion of deaths from accidents.¹³⁶
- G43. The 2009/10 GP patient survey found that older people were consistently more positive about their GP surgery than younger people. For example, 56% of 18-24 year olds said that they had confidence and trust in their doctor, compared to 78% of those aged 65 years and over. Only 36% of patients between 18 and 25 years expressed overall satisfaction with their surgery and 44% would recommend their surgery to people arriving in the local area. Patients aged 85 and over were most satisfied with their GP services (70%) and the same percentage would recommend their surgery to others, as would 72% of those aged between 65 and 84 years. Forty-five percent of parents and guardians responding to the survey were satisfied with the care they received from their GP surgery and 55% would recommend their surgery to others. As patients

under 18 are not surveyed, this may give an indication as to the quality of service provision to children and young people.¹³⁷

Sexual Orientation

- G44. Estimates from the 2009 Integrated Household Survey (IHS) response data indicate that 95 per cent of adults identified themselves as heterosexual/straight, 1 per cent of adults identified themselves as gay or lesbian and 0.5 per cent of adults identified themselves as bisexual while a further 0.5 per cent (242,000) identified themselves as 'Other'.¹³⁸ Same-sex couples formed 6,281 civil partnerships (3,227 male and 3,054 female) in the UK in 2009. The number of civil partnerships in England fell by 13 per cent in 2008 to 5,443 in 2009.¹³⁹
- G45. From the 2009 IHS, a slightly greater percentage of heterosexual respondents aged 16 and over reported being in perceived good health (78.8%) compared to 78.1% of lesbians, gay men and bisexual (LGB) respondents. On further examination of LGB figures, 80.4% of lesbians and gay men were likely to report good health compared to 73.6% of bisexual respondents. When asked whether they smoked or had smoked in the past:
- 22.7% of heterosexual respondents reported to currently smoke cigarettes and 34.9% as ex-smokers. In comparison, 33.3% of people who identified as LGB currently smoked and 32.4% were ex-smokers
 - 42.4% of adults who identified as heterosexual have never smoked, compared with 34.3% of people who identified as LGB
 - Adults aged 18 and over who identified as bisexual were less likely to smoke than those who identified as gay or lesbian: 39.8% of bisexual respondents had never smoked compared with 31.5% of gay and lesbian respondents.¹⁴⁰
- G46. Research analysing survey responses from over 14,500 gay men found that there was still a stigma attached to disclosing one's sexual identity to a GP, which, to an extent, is a reflection of wider society. However, men felt that this stigma was exacerbated when presenting with sexually transmitted infections and other pathological symptoms. In many cases, gay men were reticent to discuss sexual health issues with their GP, preferring to present at GUM clinics where they were not exposed to judgemental attitudes. For gay men with HIV, GPs tended to be even further removed from their care, as most interactions were with the specialist sexual health clinic¹⁴¹, HIV specialist care provider or personal care provider.
- G47. In conclusion, the reports authors stated that their recommendations, although not new, would be relevant for any equality group, not only gay men:
- increasing all clinic staff's capacity for meaningful communication with patients.
 - requiring all GP practices to develop and prominently display equality policies, statements and guidelines which explicitly include sexual orientation.
 - requiring all GP practices to adhere to clear guidelines around confidentiality and patient notes and to make those guidelines clear to patients.
 - requiring all staff to act according to these guidelines.¹⁴²

- G48. 'Prescription for Change', Stonewall's 2008 lesbian health survey, found that the perceptions of healthcare professions were having a direct impact on access to preventive services; 15% of lesbian and bisexual women over 25 years have never had a smear test (compared with 7% nationally) and less than half had been screened for sexually transmitted infections. Fifty per cent of women under 20 years had self-harmed compared to 1 in 15 women nationally. Half of the respondents also stated that they have not discussed their sexuality with their GP.¹⁴³
- G49. Access to appropriate mental health services for lesbian, gay and bisexual people has been highlighted as an area of concern. The 'Count Me in Too' report of the LGBT community in Brighton and Hove found that 42% of users who relied on local mental health services found them to be 'poor' or 'very poor'.¹⁴⁴

Marriage and Civil Partnerships

- G50. Under Human Rights legislation, both men and women have the right to marry and start a family, subject to national laws regulating marriage, for example the marriage of close relatives. In 2002, this right was extended to transsexual people who are now able to marry or enter civil partnerships in their acquired gender. The Civil Partnership Act 2004 means that gay men and lesbian women in the UK are now able to register civil partnerships, giving them the same rights as heterosexual married couples in areas like tax, social security, inheritance and workplace benefits.
- G51. Evidence suggests that there is a strong association between marriage and better health, particularly for men, but it has also been found that troubled marriages have negative health consequences.^{145 146} A review paper on health and civil partnerships suggested that same-sex couples could benefit from the same public health benefits enjoyed by heterosexual married couples, e.g. better mental and physical health overall and longevity. The authors also argued that increasing acceptance of same-sex civil partnerships may also have health benefits:

"...legal and social recognition of same sex relationships may reduce discrimination, increase the stability of same sex relationships, and lead to better physical and mental health for gay and lesbian people."¹⁴⁷

Religion or Belief

- G52. At the last Census, 72% of the population identified themselves as Christian. This group included the Church of England, Church of Scotland, Church in Wales, Catholic, Protestant and all other Christian denominations. People with no religion formed the second largest group (15%). Five percent of the population belonged to a non-Christian religious denomination. Of these, Muslims were the largest religious group, comprising 3% of the total population and over half (52 per cent) of the non-Christian religious population. Hindu is the third largest religious denomination, forming 1% of the total population.¹⁴⁸
- G53. According to the results of the 2006 British Social Attitude Survey, these percentages seem to have changed quite significantly since 2001.

Table G1: 'Do you regard yourself as belonging to any particular religion?'¹⁴⁹

Religion / Belief	%
Christian	47.5
Islam / Muslim	3.3
Hindu	1.4
Jewish	0.5
Sikh	0.2
Buddhist	0.2
Other non-Christian	0.4
No religion	45.8
Refused / not answered / didn't know	0.6

G54. With respect to health, the 2001 Census showed that Muslims had the highest rates of self-reported ill health (13% for Muslim males and 16% for Muslim females) once standardised for age. Hindus also reported high rates of ill health. Jewish and Christian communities were least likely to report their health as 'not good'. Muslims also had the highest rates of age-standardised disability; 25 of women and 21% men had a disability.¹⁵⁰

G55. Healthcare services need to be sensitive and responsive to the cultural and religious needs of different communities, particularly attitudes to health and well-being issues such as birth, prognosis, disease, treatment, care-giving and death.¹⁵¹ That said, it should not be assumed that all individuals from a certain religion will adhere to all practices. For example, someone who identifies as Jehovah Witness has a *personal choice* as to whether they accept certain blood products or donor organs which overrides the opinion of family or faith community leaders.¹⁵²

Socio-economic deprivation

G56. It is widely accepted that the socio-economic status of an individual can have a significant impact on their health and well-being. In communities where there are poorer outcomes in key determinants of health, such as education, employment and housing, those communities often experience poorer physical and mental health outcomes.^{153,154} For example, life expectancy is increasing overall, but a gap still persists between socio-economic groups, with the number of 'healthy years' life expectancy being lower amongst the most deprived wards.

Table G2: Years of Healthy Life Expectancy by Deprivation Level, 2009¹⁵⁵

	Men	Women
Most deprived wards	51.7	49.4
Least deprived wards	68.5	66.2

G57. In 2009, the Health Select Committee found that: 'Health inequalities are not only apparent between people of different socio-economic groups - they exist between different genders, different ethnic groups, and the elderly and people suffering from mental health problems or learning disabilities also have worse health than the rest of the population'. However, while there is evidence pointing to the differences between groups, we know a lot less about the disparities within socio-economic groups and areas.¹⁵⁶

- G58. The assertion that GPs are the most trusted health professionals is supported by the Ipsos MORI 'Trust in Professionals' survey. Overall, doctors have consistently remained the most trusted professionals above, for example, teachers, priests and the police. Trust levels reached an all time high in 2006 and 2009 of 92%. This trend tends to hold true across most demographic groups. Social class, however, does have an impact. It was found that those from more affluent backgrounds (social groups AB) were more likely to trust professionals more readily than social groups DE.¹⁵⁷
- G59. It has been reported that more deprived areas tend to have poorer access to GP services, with more affluent areas having a higher GP to patient ratios. Although most commentators tend to agree with this view, some have challenged the strength of the evidence for this, arguing that the problem is more localised, e.g. more acute in conurbations like London with large populations. Also, as there tend to be higher levels of utilisation among more disadvantaged communities, supply may not be the primary issue. Evidence also suggests that some GPs are more likely to refer the economically active and those with dependents.¹⁵⁸
- G60. Geographical distance can impact on access to health services for more vulnerable groups. The expense of travelling considerable distances to access care may result in individuals not accessing more preventive services, e.g. screening. Rates of car ownership are lower so access to out of hours services becomes particularly difficult (as public transport is less frequent at these times of the day). Lone parents or those with larger families can experience difficulty accessing appropriate childcare and support.¹⁵⁹

Homelessness

Homelessness can describe a wide range of circumstances where people lack accommodation, from sleeping rough to overcrowded or unsuitable accommodation. There are approximately 40,500 that are homeless at any one time, and 100,000 that fall in and out of homelessness each year. Around 80% of non-priority homeless people are male and between 20 and 50 years old. A study found that in 2007/08, 63% of homeless people in London were White, 20% Black or Black British, 10% from outside Europe and 5% from central and eastern Europe.

Homeless people have significantly higher levels of premature mortality and mental and physical ill health than the general population. As many as 40% of rough sleepers have multiple, concurrent health needs relating to mental, physical health and substance misuse. Approximately 60-90% of rough sleepers are regular drug users and 50% are alcohol reliant. The Cambridge Access Surgery, a homeless specialist GP practice, found that 2-3% of their homeless patients died each year between 2003-2008; the average age at death was 44 years. Rough sleepers are 35 times more likely to commit suicide than the general population.

A study of Hospital Episode Statistics showed that 86% of 'no fixed abode' episodes were admitted as emergencies compared to 42% for inpatients with a fixed place of residence. Thirty per cent of these episodes were for A&E services, compared to 3% within the general population. St Mungo's have also found that the majority of

ambulances called for their clients were for pre-existing conditions, which had reached a point of urgent attention.^{160 161}

G61. The configuration of services can be important in improving access for deprived groups. It has been argued that their higher use of A&E services is in part, due to other community-based services being perceived as too complex to access:

“The variety of new forms of service, each using their own terminology and each with a different definition of “appropriate” access that may not be easily distinguishable to some groups, may make the services less permeable than initially hoped.”¹⁶²

G62. Another reason for high attendance of disadvantaged groups at A&E could also be a result of their perceptions of their health and entitlement to care:

“People from more disadvantaged social groups tend to judge their need for treatment as event based. Thus they will often require a specific event to occur before they think it is legitimate to seek help. This also explains the lower uptake of preventive services and lack of responses to invitations for screening, immunisation etc as they are more likely to wait until there is a specific problem to report. There is also an issue about whether people feel they are entitled to ask for help and this can be linked to social class and whether people have a history of high use of services and fear being classed as “over-users”.¹⁶³

Human Rights

G63. The NHS Constitution makes the following statement:

‘You have the right to be treated with dignity and respect, in accordance with your human rights’.¹⁶⁴

G64. Human rights belong to everyone. They are the basic rights we all have regardless of who we are, where we live or what we do. Human rights represent all the things that are important to people, such as being able to choose how to live our life and being treated with dignity and respect. Human rights are based on a number of core values including Fairness, Respect, Equality, Dignity and Autonomy (also known as FRED A values). A Human Rights based approach (HRBA) is a way of ensuring that human rights principles are made real in practice.

G65. The Human Rights Act 1998 is based on the European Convention on Human Rights and includes the following articles:

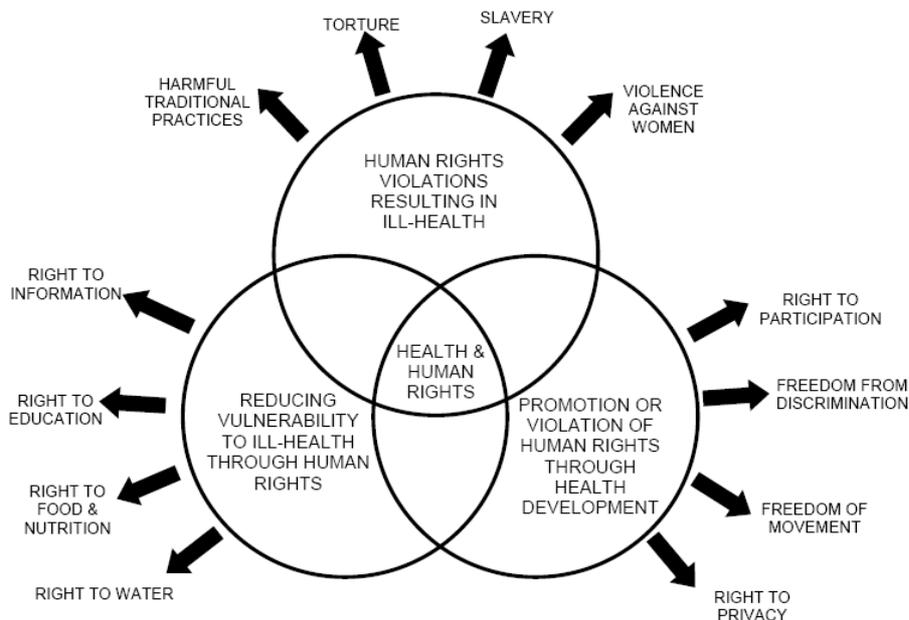
- Article 2: The right to life
- Article 3: The right not to be tortured or treated in an inhuman or degrading way
- Article 4: The right to be free from slavery or forced labour
- Article 5: The right to liberty
- Article 6: The right to a fair trial
- Article 7: The right to no punishment without law

- Article 8: The right to respect for private and family life, home and correspondence
- Article 9: The right to freedom of thought, conscience and religion
- Article 10: The right to freedom of expression
- Article 11: The right to freedom of assembly and association
- Article 12: The right to marry and found a family
- Article 14: The right not to be discriminated against in relation to any of the rights contained in the European Convention on Human Rights
- Article 1, Protocol 1: The right to education
- Article 2, Protocol 1: The right to peaceful enjoyment of possessions
- Article 3, Protocol 1: The right to free elections

G66. The annual NHS Inpatient and Outpatient surveys contain specific questions on respect and dignity shown to patients by staff.

G67. Seventy-nine percent of respondents in the 2009 inpatient survey said they felt they were “always” treated with respect and dignity and another 18% felt this was “sometimes” the case. Three percent said they did not feel they were treated with respect and dignity. There has been no change to the results of this question compared with the 2008 survey. There has been a decline in the proportion who said they were “definitely” given enough privacy when being examined or treated in the emergency department; from 76% in 2008 to 75% in 2009. A further 23% said they were given enough privacy “to some extent” (up one percentage point from 22% in 2008) and two percent (unchanged on 2008) said they were not given enough privacy in the Emergency Department.

Figure G1: Examples of linkages between health and human rights (WHO)¹⁶⁵



G68. In the 2009 outpatient survey, 87% of patients reported feeling that they were treated with respect and dignity ‘all the time’, an increase of less than one percentage point since 2004. Twelve percent stated that they were ‘sometimes’ treated with respect and dignity while the remaining

1% said that they were not. Eighty-seven percent of respondents reported that they had 'definitely' been given enough privacy when discussing their condition or treatment. Although the percentage figure has not changed from 2004, tests show that there is a statistically significant increase from 2004 to 2009. One percent of patients reported that they had not received enough privacy; no change from 2004. A high proportion of patients stated that they had enough privacy when being examined or treated: 91%, compared with 90% in 2004. The proportion of patients who said that they had not had enough privacy remained at one percent.

G69. The GP patient survey does not contain the specific respect and dignity questions found the inpatient and outpatient surveys. However, it does ask a series of questions about how individuals were treated by their doctor or practice nurse, which might indicate whether the practice of healthcare professionals is broadly consistent with human rights-based approach.

Table G3: Seeing a doctor or practice nurse at the GP surgery or health centre

Rating of doctor or nurse:	Doctor (%)	Practice Nurse (%)
Giving enough time	89	84
Listening to them	88	79
Treating them with care and concern	84	80
Taking their problems seriously	83	72
Involving them in decisions about their care	72	64

Workforce

G70. There is a total of approximately 1.3 million staff working within the NHS in England.¹⁶⁶

G71. Analysis of the 2008 NHS Workforce Census found that:

- Just over a fifth of employees were men (22%), compared to 78% women. Male staff were significantly underrepresented in nursing grades and female staff were proportionately underrepresented among senior management, medical staff and consultant roles.
- 87% of staff were White and 13% from a minority ethnic group. This broadly reflects the population as whole, however Asian and Black employees were still underrepresented at senior management levels.
- The majority of the NHS workforce is 40 years and over. The age breakdown was as follows: 15-29 year (15.4%); 30-39 (25.7%); 40-49 (31%); 50-65 (28%)
- 12% of the workforce reports having a disability, however data collection in this area less robust than for gender, age and ethnicity
- Data quality is insufficiently robust for meaningful analysis by sexual orientation and religion/belief

G72. At September 2009, there were 35,917 general practitioners in England. Of this number, 28,607 were GP Providers¹⁶⁷ and 7,310 were Other GPs¹⁶⁸ (compared to 786 Other GPs in 1999). Female doctors comprised 46.1% of the GP workforce and 61.7% of registrars (practitioners being trained for general practice).¹⁶⁹ The curriculum for GP trainees includes an element on Promoting Equality and Valuing Diversity. All trainees are expected to meet the learning outcomes outlined within the curriculum statement.¹⁷⁰

- G73. The NHS Annual Staff Survey aims to identify the major factors contributing to staff engagement and motivation to provide high quality patient care. Within the survey, there are a number of questions that focus on issues relating to equality and diversity. Questions can also be disaggregated by ethnicity, sex, age and disability, so that general responses from these groups can be analysed.¹⁷¹ The most recent survey was conducted in autumn 2009.¹⁷²
- G74. When asked whether they were satisfied with the quality of work and patient care they deliver, 83% of non-White staff responded positively, compared to 72% of White staff. Non-White staff were also more likely to agree that their role made a difference to patients. (94% and 90% respectively). However, when asked about opportunities for career progression, 79% of non-White staff felt there were opportunities, compared to approximately 90% across all staff groups. The lowest percentage was found among Black and Black British employees (69%).
- G75. The survey also asked whether individuals had undertaken any equal opportunities training in the last 12 months. Approximately 40% of staff responded positively, with younger employees between 16 and 30 years being more likely to have attended training than employees 51 years and older (50% and 36% respectively).
- G76. Non-White employees experienced considerably higher levels discrimination at work in the previous 12 months (14%) compared to their White counterparts (5%), with Black and Black British staff reporting the highest percentages (16%). Disabled employees experienced the highest levels of bullying, harassment and abuse from both patients/relatives and staff (22% and 23% respectively). There was a significant difference between male and female employees, with males experiencing less harassment (14%) than their female colleagues (20%). Black African staff were most likely to experience bullying, harassment and abuse than any other ethnic groups (22% from patients, 18% from staff).
- G77. Due to the limited intelligence on how major organisational change has impacted on equality groups, particularly within the health sector, the Department of Health's Equality and Human Rights Group commissioned the NHS Information Centre to carry out a survey to look at changes in the composition of NHS Board and senior management teams before and after the 'Commissioning a Patient-Led NHS' reforms in 2006/07. The groups covered by the survey included Chief Executives, Other Executive Directors, Other Senior Managers (non-medical staff reporting directly to Chief Executives or Other Executive Directors) and Salaried non-medical PEC members.¹⁷³
- G78. In addition to re-focussing on improving the quality of local commissioning, the reforms reduced the number of Strategic Health Authorities (SHAs) from 28 to 10, Primary Care Trusts from 303 to 152, and ambulance trusts from 29 to 12. The NHS were also implementing 'Agenda for Change', which sought to deliver a fair pay and career progression framework across the service.
- G79. Non-response and missing data from some trusts meant that the results could not be interpreted as robustly as planned. However, there were some headlines that could be gleaned from the exercise:
- There was no change in the proportion of black and minority ethnic (BME) and female staff working as NHS Executive Directors, although actual numbers fell

- There was a rise both the numbers and proportions of BME and female staff in 'Other Senior Manager' posts
- There was a fall in the number and proportion of females among salaried non-medical members of Professional Executive Committees (PECs). The number and proportion of BME members held steady.

G80. A report prepared by the NHS Information Centre for the NHS Staff Council attempted to assess the impacts of implementing the Agenda for Change¹⁷⁴ pay system, with a focus on ethnicity and gender.¹⁷⁵

G81. In general, the pay of all staff rose between 2004 – when Agenda for Change was implemented – and 2007. At a high level, there was little evidence of a systematic negative impact. However, more detailed analysis by staff grouping found at females working in administrative and clerical roles and male allied health professionals did not appear to benefit as much from the changes as other staff groups.

G82. In addition, it seemed that some small groups of low paid workers, particularly males from Pakistani, Bangladeshi and Caribbean backgrounds – also did not benefit from the Agenda for Change system in the same way as other groups, but it was unclear whether this impact was real or due to normal statistical variation seen when analysing small numbers.

G83. As NHS staff are also actual or potential users of NHS services, the effects of the changes to the commissioning landscape on staff should not be divorced from the potential impacts on patients. A recent analysis of the links between the 2007 Inpatients Survey and 2007 NHS Staff Survey found a number of associations between staff and patient experience.¹⁷⁶ Key findings included the following:

- The more staff who have had health and safety training, the better the patient perceptions of greater conscientiousness and availability of staff.
- Organisations where staff have clear, planned goals are more likely to have patients who report positive experiences of communication; in particular around patients being involved in decisions on care/treatment, family members being able to speak to doctors, the medical information patients were given, and doctors acknowledging the presence of the patient directly when talking about their case with others.
- When employees are considering leaving their organisation, it is more likely that there are poor levels of communication with patients, particularly around medicine.
- Patient perceptions of staffing levels and the respect and dignity shown towards them are correlated to employee's feelings of work pressure and staffing levels
- Prevalence of discrimination against staff is related to several areas of patient experience, particularly their perceptions of nursing staff.
- High levels of bullying, harassment and abuse against staff by outsiders relates to many negative patient experiences.
- Staff views on the confidentiality of patient information are mirrored by patient views of the privacy they are given.

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