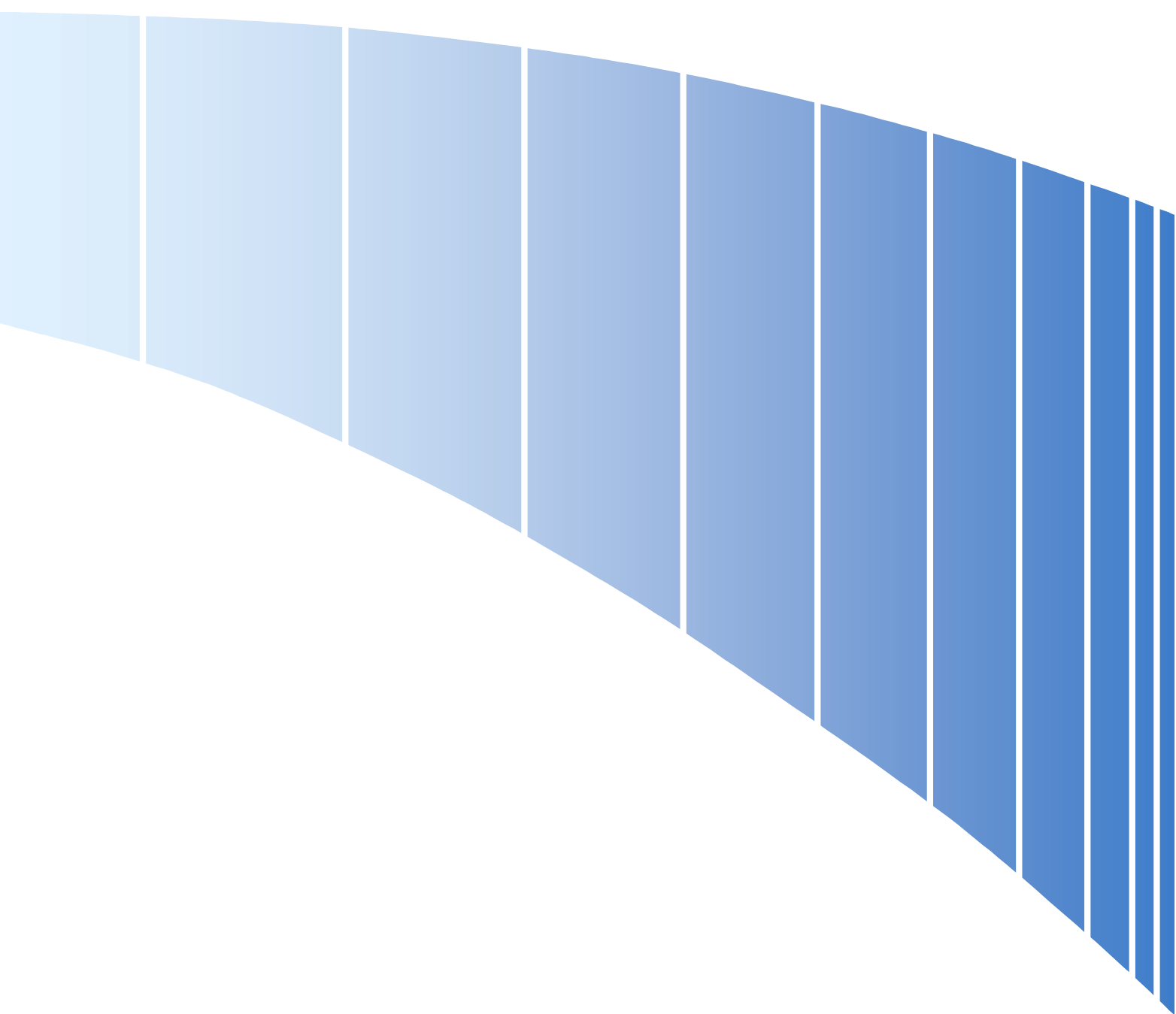


# Impact assessment: Commissioning framework for health and well-being



**DH INFORMATION READER BOX**

<b>Policy</b>	Estates
HR / Workforce Management	Performance
Planning	IM & T
Clinical	Finance
	Partnership Working
<b>Document Purpose</b>	Consultation/Discussion
<b>ROCR Ref:</b>	<b>Gateway Ref:</b> 7361
<b>Title</b>	'Commissioning framework for health and well-being'
<b>Author</b>	DH
<b>Publication Date</b>	6 March 2007
<b>Target Audience</b>	PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs, Medical Directors, Directors of PH, Directors of Nursing, Local Authority CEs, Directors of Adult SSs, PCT PEC Chairs, NHS Trust Board Chairs, Directors of HR, Directors of Finance, Allied Health Professionals, GPs, Communications Leads, Emergency Care Leads, Directors of Childrens SSs
<b>Circulation List</b>	Voluntary organisations/NDPBs
<b>Description</b>	The Commissioning framework for health and well-being will be published for consultation. It is aimed at commissioners and providers of services in health, social care and local authorities. It is part of the White Paper <i>Our health, our care, our say</i> implementation and we are consulting as part of the development of a final document to be published in Summer 2007
<b>Cross Ref</b>	Health reform in England: update and commissioning framework (July 2006)
<b>Superseded Docs</b>	White Paper (2006) <i>Our health, our care, our say</i> Local Government White Paper (2006) <i>Strong and prosperous communities</i>
<b>Action Required</b>	feedback in consultation
<b>Timing</b>	<b>Consultation closes 28 May</b>
<b>Contact Details</b>	Anthony Kealy Commissioning Policy Team Room 603 Richmond House Whitehall London SW1A 2NS 0113 2546081 www.commissioning.csip.org.uk
<b>For Recipients Use</b>	

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## 2. Partial Regulatory Impact Assessment

### Purpose and intended effect

#### Objective

- 2.2 To strengthen the commissioning undertaken by Primary Care Trusts (PCTs) for health and well-being, moving beyond treating patients just when they are ill to working with the local community to keep individuals healthy and independent.

#### Background

- 2.3 This framework follows on from the Commissioning Framework published in July 2006 as an annex to *Health reform in England: update and commissioning framework*. While that concentrated on the commissioning of services covered by payment by results, the Commissioning Framework for Health and Well-being encapsulates some of the direction of travel first described in the White Paper, namely helping people to stay healthy and to maintain their independence, as well as tackling health inequalities wherever they exist.
- 2.4 The framework is consistent with the main themes of the Local Government White Paper, which introduces the need for partnership working across PCTs, social services and wider local government in order to achieve health and well-being aims. This element of partnership would be reinforced by the proposed new duty of Joint Strategic Needs Assessment (JSNA).

#### Rationale for government intervention

- 2.5 Taking steps to encourage more effective commissioning at the local level is central to the health reform strategy of the Government. It builds on the direction of travel first set out in the NHS Plan in 2001. Commissioning is the means whereby the best value is secured for local citizens, and the process of translating aspirations and need into reality is fulfilled, and it involves specifying and procuring services for the local population.
- 2.6 With a move to a greater plurality in the providers of NHS care, it is important for the commissioning function to be sufficiently well

developed and established for the market to be managed at a local level, and to ensure that the most appropriate services are procured and the taxpayer's money is spent wisely.

- 2.7 The aspiration to achieve better health and increased well-being for everyone can only be achieved by local communities working together to tackle inequalities and promote equity. This can be supported by PCTs and local authorities working jointly to develop services that are more tailored to individuals and that are provided closer to home.
- 2.8 The Commissioning Framework for Health and Well-being seeks to remove some of the obstacles that currently stand in the way of effective commissioning activity and to support commissioners by giving guidance in a number of areas, including:
  - > developing better engagement with local people
  - > undertaking joint strategic needs assessments
  - > sharing information
  - > supporting employers and Job Centres to help people stay in work
- 2.9 There are a number of areas in England where commissioners in PCTs and local authorities are already working together and carrying out effective needs assessments. The aim of this framework, and of the duty to undertake a joint strategic needs assessment, is to ensure that the benefits of this approach are felt more widely and are transferred into those local economies where they have not yet been identified. Needs assessment by PCTs or local authorities is not new – *Developing the local government services market to support a long-term strategy for local government* (Department for Communities and Local Government, November 2006) described the local authority strategic commissioning role as “acting as a champion for local people and places by understanding and translating their needs into a strategy” – the essence of strategic needs assessment. It went on to state: “On their own, none of these practices are new; many have been deployed to positive effect by individual authorities.”
- 2.10 Commissioners can be more effective in delivering integrated care when they pool relevant information and analysis. We expect commissioners to work flexibly and to do what is necessary to share information, taking proper account of confidentiality. This may include identifying information held by other organisations (including providers) that would be useful in commissioning care, as well as sharing information between local commissioners as appropriate. The proposed minimum data set, described in Annex A of the document, will assist in this regard.

## Consultation

- 2.11 Government departments have been involved in the process of drafting the Commissioning Framework for Health and Well-being. Additionally, a number of NHS bodies and other stakeholders, including local authorities and third sector organisations, have contributed to the framework.
- 2.12 A consultation will take place for a period of twelve weeks from 6th March 2007. This will be aimed at key stakeholders, and will also provide an opportunity to comment on this partial risk impact assessment (RIA). There will also be a number of consultation events.

## Options

- 2.13 Four options have been identified:
- (i) Leave things unchanged. This will not remove the duty to undertake a JSNA. This option continues to support the precondition that PCTs and local authorities should be cooperating in order fully to understand the needs of their populations, but it does not give any detail on how this should be undertaken.
  - (ii) Rely on local drive to fully implement a JSNA and use it to make effective commissioning decisions across health and social care. This option will restrict itself to describing the duty of the PCT and the local authority (LA) to undertake a needs assessment, and will not provide guidance on implementation.
  - (iii) Provide clear guidance on how to undertake and implement a JSNA, using the proposed minimum data set. In addition, definitions of good practice in implementing and using the information drawn from the JSNA to allow effective commissioning decisions to be made jointly by the Local Authority and PCT.
  - (iv) Give detailed guidance on how to undertake a JSNA, as well as clear, detailed expectations – supported by in-depth guidance and enforcement regimes – of how the JSNA will be applied by every PCT and LA in the same way.

## Costs and benefits

### Sectors and groups affected

- 2.14 Costs and benefits would mainly fall on:
- > PCTs

- > upper-tier local authorities: counties, unitaries, London boroughs
- > NHS and NHS Foundation Trusts
- > Children's trust arrangements
- > general practitioners and other providers of primary healthcare services
- > providers who would like to offer NHS services
- > patients and service users (who would be the main beneficiaries, as they would have greater access to personalised and integrated services)

### **Race equality impact assessment**

- 2.15 Race equality impact assessment screening and an initial assessment have been completed for this framework and can be found later in this document.

### **Health impact assessment**

- 2.16 These proposals should have a significant and beneficial impact on the health outcomes of local people. They are designed to give NHS commissioners a framework for more effectively commissioning services, in ways that will move from treating sickness towards supporting the whole community in attaining the highest possible level of health and well-being. This builds on the strategies first outlined in *Our health, our care, our say* and *Health reform in England: update and commissioning framework*.
- 2.17 The health impacts of this framework will be many and varied. Due to the focus on the local determination of need, it will vary from area to area in type and structure; however, some potential health benefits that may be seen are suggested in Table 1 below.
- 2.18 The groups expected to benefit most from this framework are those receiving social care and those with long-term conditions (and risk factors associated with long-term conditions, such as hypertension). For the sake of consistency, all health outcomes are measured in quality-adjusted life years (QALYs). In Table 1 below, health benefits are outlined as a measure over a lifetime (approximately 80 years).
- 2.19 It has not been possible to measure well-being, as there is no measure of outcomes that is equivalent to QALYs for health interventions.
- 2.20 There is a caveat around attribution. Although the potential health benefits may be very large, attributing these to a change in commissioning policy may be misleading. It is not possible to say that all

these benefits stem from the framework; neither would it be correct to say that none of the benefits are attributable to the framework. Commissioning without innovation would lead to very limited health improvements. In the same way, innovation without a change in commissioning would also lead to limited health improvements.

**Table 1**

	Population	Estimated health benefits (QALYs)
<b>Smoking<sup>1</sup></b>	9,959,502	2,699,025
<b>Social care<sup>2</sup></b>	1,720,000	860,000
<b>Long-term conditions<sup>3</sup></b>		
Hypertension	6,365,837	3,182,919
Diabetes	1,890,663	945,332
Respiratory problems	3,833,693	1,916,847
Severe mental health conditions	317,122	158,561
<b>Sum of expected benefits (over a lifetime)<sup>4</sup></b>		9,762,683
Lifetime discounted benefits <sup>5</sup>		3,590,633

1 The smoking population was taken from information from the General Household Survey 2005, which indicated that 24 per cent of adults smoked. From 2006 Mid Year Estimate of populations of adults, it was calculated that 9.9 million adults smoked.

If new commissioning led to a 0.4 per cent reduction in smoking each year, then, over 80 years, the extra QALYs would be as shown. This assumption is taken from modelling work done in the paper 'Modelling the short term consequences of smoking cessation in England on the hospitalisation rates for acute myocardial infarction and stroke' by Naidoo et al., published in Tobacco Control, 2000.

2 Population using social care is taken from a 2004/05 estimate. The health benefits are estimated to be one extra QALY for half of the population. This then leads to the figure for our expected health benefits.

3 For all these conditions, data was used from Quality and Outcomes Framework 05/06 data on prevalence of the above conditions. For respiratory conditions, the numbers of patients diagnosed with asthma and chronic obstructive pulmonary disease (COPD) were combined. There may be some crossover here, though this is not thought to be large. As for social care, the health benefits assume that 50 per cent of the population gain an extra QALY over a lifetime.

4 These are the benefits estimated to accrue over a period of 80 years. The health benefits accruing from this policy are shown later, in Table 3, but they rely on the assumptions and calculations of Table 1.

5 All benefits are discounted by 3 per cent, in line with Treasury Green Book guidance for discounting benefits over 35 years.

## Rural impacts

- 2.21 No adverse impacts on rural areas are envisaged through the implementation of any elements of the framework. The crux of the approach to commissioning embodied in the framework is greater local flexibility to meet the needs of individuals and groups within the community, and this approach can also be applied to commissioning services in rural areas. This should benefit rural communities.

## Breakdown of costs and benefits

### Option (i)

- 2.22 This option assumes that a JSNA will be carried out, but that, in the absence of a framework providing clear scope for implementing the findings of the JSNA, it will be entirely up to local discretion how the results are utilised.

### Economic

- 2.23 The costs would be those of carrying out a JSNA, which are the costs outlined in Table 2, without the publishing and engagement costs. For each PCT, the costs are estimated to be about £39K. Therefore, for 152 PCTs the cost would be almost £6 million, as shown in the summary table. With no compulsion to use the JSNA, there would be no additional benefits.
- 2.24 It is assumed that a JSNA is carried out every three years, to match the three year Local Area Agreement (LAA) cycle. So the costs are only incurred once in three years (and presumably within the first year).

### Environmental

- 2.25 No new costs or benefits.

### Social

- 2.26 No new costs or benefits

### Option (ii)

- 2.27 This option relies on local drive and initiative to make the connection between undertaking the JSNA and using it to implement a more effective form of commissioning.

## Economic

2.28 In order to undertake an effective JSNA and involve patients in it, this option will cost £12 million across England. The JSNA will then help support commissioning for health and well-being. The costs to each individual PCT are detailed in Table 2 below. However, it is important to note that, as effective needs assessment is a core function of the PCT, there is no additional requirement for funding, and costs should be met out of core budgets.

**Table 2<sup>6</sup>**

<b>Policy costs</b>			
Training costs per PCT			£7,000
<b>Administrative costs</b>			
Labour costs per PCT			
Staff position	Staff time	Staff pay	Staff costs
<i>Director of Public Health</i>	5%	£80,000	£4,000.00
<i>Band 8B</i>	20%	£45,908	£9,181.60
<i>Band 6</i>	20%	£26,720	£5,344.00
<i>Band 7</i>	20%	£31,906	£6,381.20
Total labour costs			£24,906.80
Overheads <sup>7</sup>			£7,472.04
Estimated publishing costs per PCT			£20,000
Estimated cost of engaging public			£20,000
<b>Total</b>			<b>£79,378.84</b>

<sup>6</sup> This is not a new funding requirement, but forms part of the core role of the PCT.

<sup>7</sup> Overheads are calculated as 30 per cent of staff costs, as directed by Cabinet Office guidance.

2.29 Benefits from undertaking a JSNA are described in Table 3 below.

**Table 3**

<b>Benefits</b>	
Improvement in health outcomes (in QALYs)	341,889 <sup>8</sup>
Value per QALY <sup>9</sup>	£30,000
Coverage of policy <sup>10</sup>	90%
<b>Total Benefits<sup>11</sup></b>	<b>£9,231,006,949</b>

2.30 Benefits for this option are assumed to be 30 per cent of the total benefits outlined in Table 3, as the benefits from cross-working with local authorities and other local organisations will be severely reduced and will have a detrimental impact on the economic and social benefits experienced by the community.

**Table 4**

Attribution	Impact on targeted population	
	20%	50%
1%	£15,670,874	£ 27,693,021
50%	£783,543,678	£1,384,651,042

2.31 Table 4 above considers what the benefits would look like if we could more accurately attribute the effect to the policy itself, as described in paragraph 1.19. It also considers the change in benefits if the assumptions outlined in footnotes 2 and 3 were changed.

2.32 The gain in health benefits could potentially be quite large for the target groups. On the assumption that 20 per cent of the target populations will gain one extra QALY, then the benefits would be £15.6 million

8 This figure is taken as one-eightieth of the sum of expected benefits in Table 1. The one-eightieth is discounted appropriately (by 3.5 per cent for each of the three years) and each year's benefits are summed to provide this figure.

9 Each QALY gained is valued at £30,000. This value of a life year is, in turn, derived from (a) the Department of Transport's value of a statistical life, of a little more than £1 million, and (b) statistics showing that the average road death leads to a loss of about 35 years of life.

10 Coverage of policy is not necessarily going to be 100 per cent (as implied by Cabinet Office guidance), but is assumed to be substantial.

11 Total Benefits are all the components in Table 3 multiplied together. These are not cash-releasing benefits.

(assuming that the attribution of total benefits is 1 per cent). If we change the assumption about health gains, to say that 50 per cent of the target population will gain one extra QALY, then the health benefits would be equal to £27.6 million.

- 2.33 Since not all benefits can be directly attributed to the policy itself, Table 4 also considers two potential levels of 1 per cent and 50 per cent attribution, with the potential impact on the targeted population estimated at both levels.

### Environmental

- 2.34 There are no new costs or benefits.

### Social

- 2.35 The benefits detailed under economic benefits are primarily made up of social benefits, expressed through QALYs, of the increased levels of health and well-being experienced by individuals in the community.

### Option (iii)

- 2.36 This option is to provide a clear framework for how to use the results of the JSNA in order to work effectively with local authorities and other important stakeholders to achieve more effective commissioning for health and well-being.

### Economic

- 2.37 The costs of this option are similar to those expressed in option (ii) and contained in Table 2. However, as this option gives a clear recommendation that the work should be undertaken in conjunction with other local stakeholders, a line is included that recognises the costs attributable to this.

**Table 5<sup>12</sup>**

<b>Policy costs</b>			
Training costs per PCT			£7,000
<b>Administrative costs</b>			
Labour costs per PCT			
Staff position	Staff time	Staff pay	Staff costs
<i>Director of Public Health</i>	5%	£80,000	£4,000.00
<i>Band 8B</i>	20%	£45,908	£9,181.60
<i>Band 6</i>	20%	£26,720	£5,344.00
<i>Band 7</i>	20%	£31,906	£6,381.20
Total labour costs			£24,906.80
Overheads			£7,472.04
Estimated costs for other organisations involved in a JSNA			£32,378.84
Estimated publishing costs per PCT			£20,000
Estimated cost of engaging public			£20,000
<b>Total</b>			<b>£111,757.68</b>

- 2.38 Total costs for this option will be £17 million,<sup>13</sup> with £4,921,584 attributable to LA expenditure. The LA expenditure is calculated by assuming that all the organisations a PCT works with to produce a JSNA will use, at most, the same number of staff (and will therefore have the same overheads) as a PCT. Publishing and public engagement costs are assumed to be the responsibility of the PCT.
- 2.39 The estimated costs presented above are gross, not additional costs. They include costs that are currently being incurred by authorities that are already making assessments. Nor are they unfunded, new, additional costs – funding is already contained within the general grant provided by government. Where PCTs and local authorities are not already undertaking joint assessments, they are nevertheless still expected to have been undertaking assessments in isolation, jointly based on existing data and processes; in these areas, improved partnership working ought to help them realise new efficiency savings.

<sup>12</sup> As in Table 2, these are core functions of the PCT and LA and, as such, should be funded out of existing funding streams.

<sup>13</sup> Total in Table 5 multiplied by 152 PCTs.

- 2.40 The benefits are also similar to those calculated in Table 3, with the important difference being that there is a higher rate of return than the assumed 30 per cent of local areas where the work may already be taking place spontaneously.
- 2.41 Total benefits for this option could be between £52 million and £4.62 billion, depending on the assumptions used. This is shown in Table 6.<sup>14</sup> Some work that has been done within the department estimates that there are cash savings in the region of £2.5 billion, though the caveat in paragraph 1.19 still holds. Depending on attribution, the cash-releasing savings could be between £25 million and £1.25 billion.

**Table 6**

Attribution	Impact on targeted population	
	20%	50%
1%	£52,236,245	£92,310,069
50%	£2,611,812,260	£4,615,503,474

#### Environmental

- 2.42 There are no new costs or benefits.

#### Social

- 2.43 As described in option (ii).

#### Option (iv)

#### Economic

- 2.44 The costs and benefits of this option will not be materially different to option (iii).

#### Environmental

- 2.45 No new costs or benefits.

#### Social

- 2.46 There will be additional social and political costs inherent in this option, due to the perception that the beneficial effects of local discretion are being removed. While this may ensure a higher level of consistency

<sup>14</sup> As outlined in Table 6 and paragraph 1.31.

across the national picture, it may also encourage a greater spread of results, with high-achieving PCTs being those favoured by the approach, and lower-performing PCTs those that are not well suited to a blanket national approach.

- 2.47 It is important to note that, while we have concluded that this policy has no negative impacts on rural areas, this may cease to be the case if a highly regimented 'one size fits all' approach is taken across the country.
- 2.48 In order to best meet the needs of the biggest group of the population (which tends to be concentrated in conurbations), there may be a distinct move that runs counter to the needs of rural areas. This may be particularly true if the PCT or LA covers both a rural and an urban population base.

### **Small firms impact test (SFIT)**

- 2.49 We do not anticipate a significant impact on small firms. Any impact is likely to be positive, as small, private sector providers, including existing care homes and home care services, will have an enhanced opportunity to provide NHS and social care services if they meet the needs of the local health economy. However, as this is not the defined role of this framework, a full SFIT has not been undertaken.

### **Competition assessment**

- 2.50 We have carried out a competition filter and established that these measures are not expected to prevent entry into the market of health and care providers. The likely outcome is that the market will be opened up to different providers and competition will be increased.

### **Enforcement, sanctions and monitoring**

#### **Enforcement**

- 2.51 Enforcement for NHS commissioners will be through the existing mechanisms of performance management, namely the role of the Strategic Health Authority (SHA). The enforcement approach specific to the duty to undertake a JSNA is to be determined following the consultation. Additionally, the Healthcare Commission and the Commission for Social Care Inspection (CSCI) will ensure that commissioners are commissioning in an effective way; this will include their having undertaken effective needs assessment.

## Sanctions

- 2.52 We would expect sanctions to be a last resort, if the performance mechanism function of the SHA and of the Healthcare Commission and CSCI does not lead to adequate adherence by PCTs.

## Monitoring and review

- 2.53 It is expected that there will be an internal review process for the JSNA that will involve non-executive directors; this would be in addition to the inevitable review dictated by the joint nature of the JSNA. The JSNA will also be reviewed at regular intervals to ensure that it is up to date and reflects the true picture.

## Implementation and delivery plan

- 2.54 The framework will be subject to consultation. There are a number of detailed questions throughout the framework, and the responses to these questions will help in the development of a detailed implementation and delivery plan. The expectation is, however, that the framework will apply from 2008/09 onwards. In addition, we will expect commissioners to use it to inform their preparations during 2007/08.

## Post-implementation review

- 2.55 As above.

## Summary of costs and benefits and recommendation

	Costs	Benefits	Cash-releasing benefits
Option (i)	£6m	No additional benefits	
Option (ii)	£12m	£16m–£1.38bn	£8m–£376m
Option (iii)	£17m	£52m– £4.61bn	£25m–£1.25bn
of which is non-NHS expenditure	£4.9m		
Option (iv)	£17m	£52m–£4.61bn	£25m–£1.25bn
of which is non-NHS expenditure	£4.9m		

- 2.56 Option (iii) best delivers the move towards improved local partnerships, better integration and the personalisation of services and improved outcomes.
- 2.57 Option (ii) realises only a fraction of the benefits for a similar level of cost to NHS organisations, and option (iv) does not realise any additional benefits, but may lead to a marginal or perceived reduction in local discretion, which runs counter to the increased personalisation agenda.
- 2.58 This partial RIA will continue to be developed, and its assumptions tested, through the consultation process for the framework.
- 2.59 The consultation can be found at <http://www.commissioning.csip.org.uk> and will run from the 6<sup>th</sup> March to the 29<sup>th</sup> May 2007

## 2. Equality Impact Assessment - Summary Report

### Purpose of screening

- 2.1 In order to achieve Department of Health aims to increase health and well-being, commissioning policy must take account of every area of inequality and must follow the principles of social justice. The Department of Health is using screening for equality issues to ensure that the policy aims are successful, as well as to fulfil its legal obligations.

### Background

- 2.2 Inequalities in health between different ethnic groups, people with disabilities, and between men and women are well understood but are not always addressed. Problems are compounded by the difficulties some groups have in accessing services. In order to increase well-being, policy, too, must address aspects of social justice. It may be more useful to apply a social model of gender, rather than a biological one, when meeting need in commissioning.
- 2.3 The policy on commissioning for health and well-being is, on the face of it, an ideal policy to promote equality. Statements within the early papers are very inclusive of all groups of the population. That means, almost as a default, that it should be subject to a full impact assessment.<sup>15</sup> But there is a huge diversity in the environment in which the policy operates.
- 2.4 The Prime Minister's Strategy Unit Report *Improving the life chances of disabled people* uses the social model of disability, that is, "the disadvantage experienced by an individual as a result of barriers (attitudinal, physical, etc.) that impact on people with impairments and/or ill health". The report estimates that there are 11 million disabled adults and 770,000 disabled children in the UK. The Disability Rights Commission website points out that:

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<sup>15</sup> The purpose of screening is to assess whether a proposed policy is *relevant* to the various equality duties. This means looking at the extent to which a proposed policy has the *potential* to have a differential or negative effect on equality.

“Disabled people, who make up around a third of NHS users in Britain, die earlier, often from preventable illness, experience unequal access to health services, including cancer screening, immunisation and primary healthcare generally. Without more equal health outcomes, disabled people will not establish equal life chances. Health strongly influences opportunities to work, participate, exert control, live independently and to get on in life.”

- 2.5 As well as the direct problems that people with disabilities may have, this very neatly describes some of the tensions that this policy on health and well-being is trying to correct. The issues described are equally relevant for black and minority ethnic (BME) and gender issues. A key success marker for commissioning policy will be how implementation of disability equality schemes are managed and monitored. The same principle of monitoring applies with regard to BME and gender issues.

## Findings

- 2.6 Problems with managing health and social justice issues for BME groups and for people with disabilities often arise because there is insufficient regard to outcomes. While there are instances of best practice, too often a narrow health model is employed, rather than a social model with health as an aspect. Attitudes are unconsciously patronising, with the NHS and partners pronouncing on need, rather than responding to it. There is sometimes excessive concern about the expense, rather than the challenge, in producing equal outcomes – and therefore concern about whether the market will fairly address issues.
- 2.7 Generally, in commissioning nowadays, there is insufficient representation from each community. And where there is representation, it tends to be from articulate, literate male representatives, rather than from women, who may be less visible.
- 2.8 There are areas of social expertise that commissioners may lack. While most people understand health inequalities, they do not understand social justice issues quite so well, and may fail to grasp, inadvertently, just how entrenched and difficult discrimination can be. Currently, services are generally set up to benefit the majority of users and may ignore different needs.
- 2.9 In terms of working jointly and ensuring appropriate provision for people with disabilities, the existing arrangements for commissioning for health and well-being are weak. Aside from the issue of people with mental health problems or with a learning disability, who are most at risk of

discrimination, there are poor transitional arrangements between child and adult services.

- 2.10 Good individual needs assessment is the absolute prerequisite, especially for hard-to-reach groups and those with less usual needs.
- 2.11 The voluntary/charitable sector has, in many ways, greater expertise than commissioners in the needs of people from different ethnic groups and with simple and complex disabilities.

### Information

- 2.12 Census data is dated: there is little information on the basis of gender, and the information on disabilities that the NHS itself holds at a local level is scant. There is often no knowledge of particular needs, or even of different sources of provision or of how to manage the two greatest needs – better access and better information. Many people – not just those with equalities issues – are worried about how information might be used in the future. There is great concern surrounding large databases. Even anonymised data needs careful handling.
- 2.13 It would be wrong to assume that feeding statistics to people will necessarily make a difference; that if you give people knowledge it changes behaviour – even knowledgeable health professionals, who know what they should be doing, may continue to have a poor diet themselves, for example. It is all the more difficult, then, to get the message across to people who may be hard to reach or who have communications problems.

### The market

- 2.14 In market development and the search for efficiencies, there may be several interacting risks to equality.
- 2.15 Within the market place, an annual commissioning round can create uncertainty among the new providers – including small voluntary sector groups operating on a shoestring.

### Access

- 2.16 Services should be commissioned in the right settings and should take account of different access issues: ramps, for example, do not help blind people.

### **Education and training**

- 2.17 Buffers between the service and the patient should be countered through equality awareness programmes.

### **Research**

- 2.18 As well as monitoring, every good policy is underpinned by a subsequent research evaluation.

### **Finally**

- 2.19 While the policy is broadly acceptable, is moving in the right direction, and should help to ensure better commissioning (and therefore provision), there are plenty of individual issues that will only become significant during implementation. Overall, in order for the policy to be successful, we would recommend that local commissioners follow best practice, including:
- > accurate ethnic monitoring, using widely accepted coding
  - > seeking out different groups and individuals
  - > addressing access issues
  - > differential application of policy to different groups and individuals
  - > extra resources devoted to addressing differential need or hard-to-reach populations or individuals
  - > appropriate training for health professionals and managers
  - > development of appropriate local quality criteria
  - > continuing evaluation and systematic audit

### **Requirements for successful consultation**

- 2.20 The consultation must be managed, so that all interested parties can give their views. Good and varied communication methods should be used, and interested parties should be directly sought out, including representatives of both genders with a disability or who are from BME groups. Some suggested consultation questions are given below.

## Consultation questions to meet the objectives of impact assessment

General questions for consultation would include:

- > Does the policy move towards delivery of equity of social justice and health outcomes for different populations, including BME (and disabled) groups and individuals of either gender?
- > Does the policy give sufficient weight to
  - accurate ethnic monitoring
  - addressing access issues for hard-to-reach groups
  - seeking out hard-to-reach groups?
- > Does the policy address the resource issue for service delivery to BME and disabled groups of either gender?
- > Are there risks for BME and disabled groups of either gender in the efficiencies the policy is addressing?
- > What would be the markers of success in improving social justice for, and the health of, BME and disabled groups of either gender?

## Specific issues

2.21 The following, more specific, **statements and questions** are also for consultation and discussion.

- > Should everything be contained in a single, final policy document, or should complementary publications be referenced for example, *Creating a Disability Equality Scheme: A Practical Guide for the NHS*, published by the Department of Health in October 2006?
- > Will commissioning, as described in the policy, be enabling, so that service provision fits with what people want to do themselves – or do in fact do themselves – in their normal lives?
- > Although they do make good partners, people in the voluntary sector should not just be involved in provision. What role should the voluntary sector have in the annual commissioning round, and specifically in the strategic needs assessment?

- > How can there be appropriate participation by people in this sector in individual commissioning decisions taken in year? At this level, there is a whole spectrum of people, and this requires a flexible approach. There are people who are competent and wish to hold their own budgets; people who wish to have a say in how the money is spent; people who are too fatigued and depressed to take part; people whose disability makes decisions difficult or difficult to understand; people who want to be consulted; and people who want to leave everything to the professional services. So are there different ways of ensuring that involvement is genuine, and not just tokenistic?
- 2.22 Appropriate consultation will be expected as part of the work on the PCT Prospectus. Does that mean:
- > involvement should happen at two levels: local organisations and individual people? It should not always be the strongest voice that counts. It should not be a self-selected group
  - > sometimes people with disability or from a BME group should do the consultation?
  - > GP lists should help to identify people with disability or BME issues?
  - > giving feedback to those consulted about the outcome of the consultation and the decisions taken? Consultation fatigue can result from lack of communication after consultation
- 2.23 Should commissioners consider financial support for national and local organisations – and individuals – to take part in commissioning?
- 2.24 Should people running genetic services be more involved in commissioning? They have a good understanding of the effect of some disabilities, including among people with less usual needs. Similarly, should appliance services be more closely involved?
- 2.25 Is there enough joining up nationally, between government departments, including the Department for Work and Pensions (DWP), as well as locally and between health and non-health services? For example, local job centres have much expertise through disability employment advisers.
- 2.26 Commissioning for an integrated service is particularly important in the sector of people with disabilities. It should embrace all services more effectively, so that, for example, it includes provision of transport or of appliances. Is that covered?
- 2.27 In this area in particular, while novel solutions will often deliver greater benefits, stability for both provider and user is all important. An annual commissioning round is time consuming and gives no direction; should

consideration be given to longer periods, such as three-year rolling contracts?

## Information

- 2.28 In managing information issues, are the following statements correct?
- > Commissioners must be especially sensitive to issues of confidentiality. Even with anonymisation, small groups may be more easily identified.
  - > People should be reassured about how the information will be used and that it will be anonymised and, in some circumstances, destroyed after use.
  - > Monitoring information should be collected, if possible, as part of a single patient record, and should follow the patient through health service and social care services.
  - > Management of confidentiality issues should be monitored.
- 2.29 In presentation of information, are the following statements correct?
- > There should be a wide variety of formats available.
  - > Information should be in plain language and be ‘friendly looking’; it should have pictures and illustrations. Large fonts and good colour contrasts always help.
  - > Information should be multi-layered – directed at disabled people, as well as at carers.
  - > Most people cannot access non-visual information.
  - > For many disabled people, and particularly BME disabled people, it is better to impart information face to face.
  - > Disabled people should be involved in drawing up information for the public.
- 2.30 Do the Department of Health and other government departments need to set standards for PCTs, health trusts, local authorities and others on better communication? (See Healthcare Commission core standard C16 below.)

## Evaluation

- 2.31 Do the Healthcare Commission core standards provide a good performance management framework to judge success at a local level, and should a recommendation to use them be included?<sup>16</sup>

## Education and training

- 2.32 In the section on increasing capability for commissioning, should the guidance point out the need for training in equality and human rights issues, as in the Department of Health paper *Equality and Human Rights in the NHS – A Guide for NHS Boards*, published on 11 December 2006.
- 2.33 There are difficult issues within education and training. As one (blind) informant said: “Clearly there are issues around competencies for current commissioners, particularly for minorities; competencies are least met in social care. But culture may be more important.” So how can training deal with problems in organisational and individual culture?

## Access

- 2.34 Issues go down to an individual level – in terms of access, people who are blind, deaf, physically challenged or who have a learning disability have personally different needs. At the least, commissioners should ensure that premises are fit for purpose and that appropriate transport provision is considered. Are those statements sufficient?

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<sup>16</sup> The issue of equality and human rights runs through a number of core standards, such as:

- Core standard C6: Healthcare organisations cooperate with each other and social care organisations to ensure that patients’ individual needs are properly managed.
- Core standard C13: Healthcare organisations have systems in place to ensure that staff treat patients, their relatives and carers with dignity and respect.
- Core standard C16: Healthcare organisations make information available to patients and the public on their services, provide patients with suitable and accessible information on the care and treatment they receive and, where appropriate, inform patients on what to expect during treatment, care and aftercare.
- Core standard C17: The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving healthcare services.
- Core standard C18: Healthcare organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably.
- Core Standard C22: Healthcare organisations promote, protect and demonstrably improve the health of the community served and narrow health inequalities.

## Conclusion

- 2.35 Is inclusiveness demonstrated in this policy? There is a clear parallel with other equalities issues, and it may be right to consider them in the round, at the same time as keeping individual need very much in mind. As described in paragraph 3.14, is a key success marker for commissioning policy how implementation of the Disability Equality Scheme, together with gender and BME issues, is managed and monitored?

## Acknowledgements

- 2.36 With many thanks to Dr Philip Leech, OBE, for his work on this impact assessment.

## 3. Equality Impact Assessment - Full Report

### Purpose of paper

- 3.1 This paper forms part of a formal screening process for racial equality impact (REI), gender and disability equality impact on the national policy for commissioning for health and well-being. It should be read alongside the pro forma (see below), which answers specific screening questions on different aspects of the policy. It also describes issues to be taken into account in consultation, if the policy is to succeed in an impact assessment.

### Introduction

- 3.2 **REI impact assessment is a legal requirement**<sup>17</sup> it is unlikely that there will be no relevance in health policy. The strict purpose of REI screening of policy is to establish if the overall policy and the parts therein are relevant to BME populations. The relevance is **not confined to the effects of policy on health, but extends also to other inequalities issues**. Similarly, from April 2007, public bodies have a duty to ensure **equality in gender issues** as they are related to health and well-being.<sup>18</sup> **Equality impact assessment is also a legal requirement in order to promote equality for those with a disability.**<sup>19</sup>

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<sup>17</sup> The Race Relations Act 1976 (as amended by the Race Relations (Amendment) Act 2000).

<sup>18</sup> The Equality Act 2006 has provisions that create a duty on public authorities to promote equality of opportunity between women and men (the “gender duty”), and prohibit sex discrimination in the exercise of public functions. This also includes a specific duty on public bodies to produce a Gender Equality Scheme. The gender duty will come into force in April 2007.

<sup>19</sup> The Disability Discrimination Act 1995 prohibits discrimination against disabled people in the areas of employment, the provision of goods, facilities, services and premises, and education, and provides for regulations to improve access to public transport to be made. The Disability Discrimination Act 2005 makes substantial amendments to the 1995 Act and places a general duty on public authorities to promote disability equality and to have due regard to – and specific duties in – eliminating unlawful discrimination. The specific duties include provision of a framework for meeting the general duty and include the requirement to produce, from December 2006, a Disability Equality Scheme. It requires the Department of Health, when carrying out its functions, to have due regard to the need to (among other things): promote equality of opportunity between disabled persons and other persons; eliminate discrimination that is unlawful under the Act; promote positive attitudes towards disabled persons; encourage participation by disabled persons in decision-making structures

## Department of Health (DH) aims

- 3.3 The DH aspires to build an integrated health and social care system that can respond flexibly to increasing individual expectations, as well as demographic challenges. The DH aims to improve the health, well-being and independence of all and to deliver flexible, integrated services, responsive to the needs and wishes of each person as an individual. In order to achieve that and to increase well-being, commissioning policy must take account of every area of disability and follow the principles of social justice. And, as a recent DH publication for NHS boards says:

“The connections between commissioning activity and equality and human rights is implicit, as properly designed and executed commissioning both reduces health inequalities and can act to promote equality of access and health outcomes.”<sup>20</sup>

## Background

### Race equality impact (REI)

- 3.4 Inequalities in health between different ethnic groups, and between men and women in these groups, are well understood but are not always addressed.<sup>21</sup> Problems are compounded by the difficulties some groups have in accessing services. The circumstances of black and minority ethnic (BME) people are also affected by factors that include time of immigration, culture, language, education, employment history, gender, geographical location and housing conditions, health status and family.<sup>22</sup> In order to increase well-being, policy, too, must address aspects of social justice.
- 3.5 The policy on commissioning for health and well-being is, on the face of it, an ideal policy to promote equality. Statements within the early papers are very inclusive of all groups of the population. That means, almost as a default, that it should be subject to a full impact assessment.<sup>23</sup> But in

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and processes; and take steps to take account of disabled persons' disabilities, even where that involves treating disabled persons more favourably than other persons.

<sup>20</sup> *Equality and Human Rights in the NHS – A Guide for NHS Boards*, published 11 Dec 2006.

<sup>21</sup> Described in *A practical guide to ethnic monitoring in the NHS*, DH/Health and Social Care Information Centre/NHS Employers, July 2005.

<sup>22</sup> Derived from 'Black and Minority Ethnic Elders' issues', Policy Unit, Age Concern England, Astral House, 1268 London Road, London SW16 4ER. September 2002.

<sup>23</sup> The purpose of screening is to assess whether a proposed policy is *relevant* to the various equality duties. This means looking at the extent to which a proposed policy has the *potential* to have a differential or negative effect on equality.

developing the policy, there is a huge diversity in the environment in which it operates. For example:

- > in Newham there are twenty different ethnic groups, speaking 137 languages and comprising 60 per cent of the population, while
- > in neighbouring Tower Hamlets there is a large Bangladeshi population
- > in Lincoln the minority groups are mostly Portuguese and Chinese
- > in Doncaster 94.1 per cent of the population is white British
- > in West Sussex there is no measurable ethnic diversity

## Gender

- 3.6 Emphatic differences between men and women emerge in different ways, at different times and in different circumstances. There is a web of gender issues between health and well-being, and social justice. While there is some awareness of health differences between men and women and children of either gender, biological gender issues alone do not give rise to the differences. There is a complex overlay, often involving black and minority ethnicity, religious belief and culture. It may be more useful to apply a social model of gender, rather than a biological one, when meeting need in commissioning.
- 3.7 There are biological and social differences between men and women for all medical conditions, and this involves recognition issues for commissioners. Are commissioners aware that, while osteoporosis is more frequent in women, it is more often fatal in men? Some 20 per cent of recorded eating disorders occur in men, but we believe that may not be the true prevalence.
- 3.8 An extensive academic and policy literature has built up on different and specific women's issues, with much of it focusing on health and social need; the literature on men's issues is slimmer, so there may be a gender bias in knowledge. There is, however, a growing literature on gender issues, health and social justice generally.

## Disability

- 3.9 The Prime Minister's Strategy Unit Report *Improving the life chances of disabled people* uses the social model of disability, that is, "the disadvantage experienced by an individual as a result of barriers (attitudinal, physical, etc.) that impact on people with impairments and/or ill health". The report estimates that there are 11 million disabled adults

and 770,000 disabled children in the UK. The Disability Rights Commission website points out that:

“Disabled people, who make up around a third of NHS users in Britain, die earlier, often from preventable illness, experience unequal access to health services, including cancer screening, immunisation and primary healthcare generally. Without more equal health outcomes, disabled people will not establish equal life chances. Health strongly influences opportunities to work, participate, exert control, live independently and to get on in life.”

- 3.10 As well as the direct problems that people with disabilities may have, this very neatly describes some of the tensions that this policy on health and well-being is trying to correct.
- 3.11 Some examples of BME health, gender differences and disability issues are at annexes A, B and C.

## Discussion of policy aims

- 3.12 **The policy on commissioning for health and well-being is a good policy to move towards equality of outcomes** in the areas of this report. Statements within policy papers are inclusive of all groups of the population. That means that the policy should be subject to a full impact assessment. Every aspect of the policy on commissioning for health and well-being may affect people of either gender, from different ethnic groups or with a disability.
- 3.13 Not all the steps necessary for successful delivery in terms of equalities need be on the face of commissioning policy. However, for example, if actions included in the legislation are put in place, then public bodies, including the Department of Health, must have Disability Equality Schemes, demonstrating how they intend to fulfil their general and specific duties under the Act. This includes the principle that a public authority should involve disabled people in the development of the scheme, and the scheme should include a statement regarding:
  - > the way in which disabled people have been involved in the development of the scheme
  - > methods for impact assessment
  - > steps towards fulfilling the general duty (the “action plan”)
  - > the authority’s arrangements for putting the information gathered to use, in particular in reviewing its action plan and in preparing the next Disability Equality Scheme (DES)

- 3.14 This implies that a key success marker for commissioning policy will be how implementation of the DES is managed and monitored. The same principle of monitoring applies with regard to BME and gender issues.

## Methodology

- 3.15 Screening was carried out by referring to the appropriate literature, including legislation; examining research evidence on the effects of ethnic status, gender or disability on equality; and taking statements from stakeholder organisations, including statutory bodies with responsibilities in the area, but mostly from the charitable and voluntary sector. It also included the views of policy leads and managers, discussions with carers, and it gained much from a range of interviews with carers or people with different disabilities and from different ethnic groups.

## Findings

### REI

- 3.16 Problems with managing health and with social justice issues for BME groups often arise because there is insufficient regard to outcomes. While there are instances of best practice, too often a narrow health model is employed, rather than a social model with health as an aspect. Attitudes are unconsciously patronising, with the NHS and partners pronouncing on need, rather than responding to it.
- 3.17 There is insufficient acceptance of cultural differences, and therefore insufficient thought about novel solutions that fit the needs of what may be very strong communities. On the other hand, where there is awareness, there is sometimes concern about the expense, rather than the challenge, in producing equal outcomes – and therefore concern about whether the market will fairly address issues.
- 3.18 Generally, in commissioning nowadays, there is insufficient representation from each community. And where there is representation, it tends to be from articulate, literate male representatives, rather than from women, who may be less visible.
- 3.19 It is not clear if commissioners are looking at longer-term benefits. Many BME groups are young, and it is therefore important to get this right – although forecasting morbidity in younger populations is difficult. There are big social and health risks for overlooked young people, who are disproportionately represented in BME groups.

- 3.20 Commissioning for acute services is often perceived as more pressing than commissioning for health and well-being – and indeed is closer to most commissioners’ expertise, which means it tends to get priority. There are areas of social expertise that commissioners may lack. While most people understand health inequalities, they do not understand social justice issues quite so well, and may fail to grasp, inadvertently, just how entrenched and difficult discrimination can be. Currently, services are generally set up to benefit the majority of users and may ignore different needs. As one respondent to the screening process said: “The system currently relies on people not asking for care.” In the case of BME groups, this must change.

## Gender

- 3.21 Alongside differences in physical illness (such as sex-specific differences, e.g. prostate disease, or a higher prevalence of heart disease in men than in pre-menopausal women), there are attitudinal differences. In some societies, men may be overly stoical or women unaware. Men are admitted to hospital from Accident & Emergency twice as often as women, usually because of a long-term condition. On the other hand, women do not recognise, until late on, that their chest pain may be a coronary thrombosis. Self-care by middle-aged men (who prevaricate over health issues) is poor. The service does not always recognise that.
- 3.22 There is often different prioritisation between men and women; men are bad at looking ahead and may need more education. Two examples: compared to women and their knowledge of breast cancer, men are relatively ignorant about prostate cancer; and while men may think testicular cancer could kill them, there are actually only 80 deaths annually, compared with 3,000 suicides.
- 3.23 Education and enablement – or the opposite – begins at school. Patterns are set before adolescence – with family and cultural values acting on an immature population. In those cultures apparently dominated by men, women may not have more than an elementary education or may find it difficult to access services.
- 3.24 As well as these differences, there are complex interactions at different levels. Men may carry chlamydia infection silently and pass it on to women sexually, with devastating effects on health and fertility; in some cases, it is impossible to say what the prevailing influence is. For example, among babies born in England and Wales to mothers who were born in Pakistan, the infant mortality rate was 8.9 per 1,000 births in 2004 – almost double the national average. Is this caused by ethnicity,

or by a health or social disadvantage by gender, through having more difficulty in accessing care. Or is it more about deprivation generally?

- 3.25 All aspects of the commissioning framework can relate to gender sensitivity. Apart from specific forays into development, and delivery of specific surveys that are more obviously gender specific (such as testicular cancer or cervical screening), no policy has considered men's or women's health and social justice issues before.
- 3.26 In England, while there is a Men's Health Forum interest group, there is no similar group on women's health.
- 3.27 In general terms, services may discriminate against men in terms of:
- > access – opening hours during the working day are more commonly a barrier to men
  - > the interface before accessing a health professional – by far the majority of receptionists are women and they may not recognise the unexpressed health needs of male patients.
  - > information – which is unlikely to be gender specific
- 3.28 Similarly, yet differently, services may discriminate against women in terms of access, poorly understood need and poor information.
- 3.29 Chaperoning and personal support at the encounter is a poorly understood issue in relation to men.

## Disability

- 3.30 In terms of working jointly and ensuring appropriate provision for people with disabilities, the existing arrangements for commissioning for health and well-being are weak. While good work is being done, there is evidence of uncertainty, lack of knowledge, and concentration on budgetary issues. While there is much diversity in disability, some groups suffer worse commissioning and provision than others. As a report from the Disability Rights Commission (DRC) says:

“We have repeatedly heard from witnesses how people with disabilities, including people with mental health problems and/or with learning disabilities and, to an extent, Black and Minority Ethnic people, remain largely invisible in national policy and priorities for health inequalities. ... This problem is compounded by the absence of indicators in the health inequalities baseline measures and in other national data collections.”

And:

“Those inequalities have been allowed to persist partly because people with learning disabilities and mental health problems all too often have reduced expectations of their physical health and of the services to support their physical health. That has been compounded by low expectations on the part of practitioners and policy makers.”<sup>24</sup>

- 3.31 Aside from the issue of people with mental health problems or with a learning disability, who are most at risk of discrimination, there are poor transitional arrangements between child and adult services.
- 3.32 The quotation above demonstrates a crossover with BME issues; in many ways people with disability suffer the same problems as BME groups, who are often underprivileged or financially challenged.<sup>25</sup> Groups may have difficulty accessing services, and local understanding of need is imperfect – as Rob Grieg, National Director for Learning Disability, says: “It is not the disability that is the problem, but society’s attitude to it.”

## Further overarching findings

### Sensitive and specific commissioning

- 3.33 Good individual needs assessment is the absolute prerequisite, especially for hard-to-reach groups and those with less usual needs. This implies a very strong need for a knowledgeable commissioner who has carried out a comprehensive strategic needs assessment. Needs assessment is more difficult if people are reticent or have difficulties in communication. Research from Bristol University (published in 2003) described “gender blindness” in policy; this may well exist in commissioning too.
- 3.34 Commissioning must work for people who may have a disability that is recognised by others, but either is not acknowledged or is denied by them. It may appear immaterial in their expectations, or in how they manage their lives. But that, or their gender, or ethnicity, will still affect how services are commissioned.
- 3.35 Commissioners may also need to commission for different needs stemming from the same disability. Future support for a professional violinist who loses the little finger of the left hand is likely to be different

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<sup>24</sup> Report of the DRC Formal Inquiry Panel to the DRC’s Formal Investigation into the inequalities in physical health experienced by people with mental health problems and people with learning disabilities.

<sup>25</sup> “Disabled people remain more likely to live in poverty, to have fewer educational qualifications, to be out of work and experience prejudice and abuse. They still routinely find themselves experiencing poorer services” – Tony Blair, in the report *Improving the life chances of disabled people*, Cabinet Office, 2005.

from the support required by a lecturer in modern languages who loses that finger.

### National and local cross-sector joint working

- 3.36 While government departments are working in a more joined-up way, the outcomes in terms of coherent policymaking and implementation are still imperfect. This is reflected locally in the interaction between local government and local offices of national government, such as Jobcentre Plus. One informant said that he had had more support for managing his disability issues from Access to Work<sup>26</sup> than from all the health and social services, but disability employment advisers are not directly connected to other services. Reflecting that, appliance services appear to be a Cinderella service, except possibly for low vision aids.
- 3.37 The voluntary/charitable sector has, in many ways, greater expertise than commissioners in the needs of people from different ethnic groups and with simple and complex disabilities. Organisations within the sector may even have wider knowledge than the NHS about prevalence, and may be more able to identify the population that could be in receipt of services.

### Information

- 3.38 Census data may not be the best source of information on BME issues, thanks to shifting populations, recent movements of refugees, and incomers from Eastern Europe. Information from GP lists may be more important; however, ethnicity is still relatively poorly recorded.
- 3.39 There is little information on a gender basis (other than for specific diseases). Therefore, there is little idea of how to promote self-care, for example. It should be possible to develop this area through national sociological techniques so as to inform local commissioners. Empowerment depends on earlier education and better information. Utilisation of primary care services by girls (who are most often taken by their mothers) is twice as frequent as by boys aged 5–14.
- 3.40 The information on disabilities that the NHS itself holds at a local level is scant. There is often no knowledge of particular needs, or even of different sources of provision. The two greatest needs of people with disability are for better access and better information. One blind person said: “I just want a little candle to light my way through.” Illustrating the

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<sup>26</sup> This service is supported by Department for Work and Pensions through the disability employment advisers.

complexity, Leeds City Council has produced a booklet, *Negotiating the Maze*, with reference to the support that *can* be accessed by people with disability – if they can find it.

- 3.41 Many people – not just those with equalities issues – are worried about how information might be used in the future. There is great concern surrounding large databases.
- 3.42 Even anonymised data needs careful handling – one example could be the effect that a concentration of people with HIV in a small geographic area has on that area.
- 3.43 It would be wrong to assume that feeding statistics to people will make a difference; that if you give people knowledge it changes behaviour – even knowledgeable health professionals, who know what they should be doing, may continue to have a poor diet themselves, for example. It is all the more difficult, then, to get the message across to people who may be hard to reach or who have communications problems.

### The market

- 3.44 In market development and the search for efficiencies, there may be several interacting risks to equality. As one informant said, care needs to involve 100 per cent of people, not 100 per cent targets, with narrow ideas of health gain within those targets.
- 3.45 Within the market place, an annual commissioning round done at the last minute would be difficult; it would create uncertainty among the new providers – including small voluntary sector groups operating on a shoestring.

### Access

- 3.46 Services should be commissioned in the right settings. For example, well man checks might be better at the workplace or job centre, rather than at the GP's surgery.
- 3.47 The NHS does not always provide good access to people with disabilities: standard signing and ramps do not help the blind. (And, as one partially sighted informant said, "beware glass doors".) Commissioners should look to experts such as the RNID to provide simple advice and build it into commissioning plans.<sup>27</sup>

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<sup>27</sup> Simple advice might include:

## Education and training

- 3.48 There is a problem with the culture of the professions and the culture of the community. There are buffers between the service and the patient, instead of facilitation. These should be countered through equality awareness programmes. As the previously quoted *Equality and Human Rights in the NHS – A Guide for NHS Boards* (published 11 December 2006) says:

“It is therefore vital that you satisfy yourself that adequate **education and training** relating to equality and human rights is delivered in your organisation. Ensuring that the appropriate level of equality competences are incorporated within the **Knowledge and Skills Framework** at the appropriate level for different grades of staff can make considerable progress towards driving the required shift in understanding, attitudes and practices.”

## Research

- 3.49 As well as monitoring, every good policy is underpinned by a subsequent research evaluation. Just one example might be to examine the difference in the way the sexes are motivated to accept a life change or treatment. No specific research has identified clearly why it is that twice as many men aged over 50 as women are admitted to hospital through Accident & Emergency departments. With good research, it should be possible to commission services to improve this. Nothing of the kind has been done before on a gender basis, and it could make a big difference to health outcomes and service utilisation.

## Finally

- 
- Ask patients how they prefer to communicate and add a note to the person's records.
  - Allow more time for appointments.
  - Have a display board to announce the next appointment.
  - Provide communication support, such as a sign language interpreter.
  - Provide helpful equipment, such as an induction loop.
  - Make sure staff are aware of RNID Typetalk, this service allows communication between textphones and telephones.
  - Remember to face your patient and use other communication tips.
  - At least one front-line staff member should have basic deaf awareness training.

- 3.50 While the policy is broadly acceptable, is moving in the right direction, and should help to ensure better commissioning (and therefore provision), there are plenty of individual issues that will only become significant during implementation. Overall, in order for the policy to be successful, a number of measures should be undertaken, including:
- > accurate ethnic monitoring, using widely accepted coding
  - > seeking out different groups and individuals
  - > addressing access issues
  - > differential application of policy to different groups and individuals
  - > extra resources devoted to addressing differential need or hard-to-reach populations or individuals
  - > extra training for health professionals and managers
  - > development of appropriate standards
  - > inspection and continuing evaluation

### **Requirements for successful consultation**

- 3.51 The consultation must be managed, so that all interested parties can give their views and should use:

- > good communication
- > specific questions that must be answered
- > web-based questionnaires

together with

- > knowledge of good existing practice in the NHS
- > health equity audits

and the consultation should involve

- > expert groups, including charitable and voluntary sector organisations
- > users and carers from the different groups

### **Consultation questions to meet the objectives of impact assessment**

- 3.52 General questions for consultation would include:

- > Does the policy move towards delivery of equity of social justice and health outcomes for different populations, including BME (and disabled) groups and individuals of either gender?
- > Does the policy give sufficient weight to
  - accurate ethnic monitoring
  - addressing access issues for hard-to-reach groups
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- > Does the policy address the resource issue for service delivery to BME and disabled groups of either gender?
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- > What would be the markers of success in improving social justice for, and the health of, BME and disabled groups of either gender?

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- > Should everything be contained in a single policy document, or should complementary publications be referenced for example, *Creating a Disability Equality Scheme: A Practical Guide for the NHS*, published by the Department of Health in October 2006?
- > Will commissioning, as described in the policy, be enabling, so that service provision fits with what people want to do themselves – or do in fact do themselves – in their normal lives?
- > Although they do make good partners, people in the voluntary sector should not just be involved in provision. What role should the voluntary sector have in the annual commissioning round, and specifically in the strategic needs assessment?
- > How can there be appropriate participation by people in this sector in individual commissioning decisions taken in year? At this level, there is a whole spectrum of people, and this requires a flexible approach. There are people who are competent and wish to hold their own budgets; people who wish to have a say in how the money is spent; people who are too fatigued and depressed to take part; people whose disability makes decisions difficult or difficult to understand; people who want to be consulted; and people who want to leave everything to the professional services. So are there different ways of ensuring that involvement is genuine, and not just tokenistic?

- 3.54 Appropriate consultation will be expected as part of the work on the PCT prospectus. Does that mean:
- > involvement should happen at two levels: local organisations and individual people? It should not always be the strongest voice that counts. It should not be a self-selected group
  - > sometimes people with disability or from a BME group should do the consultation?
  - > GP lists should help to identify people with disability or BME issues?
  - > giving feedback to those consulted about the outcome of the consultation and the decisions taken? Consultation fatigue can result from lack of communication after consultation
- 3.55 Should commissioners consider financial support for national and local organisations – and individuals – to take part in commissioning?
- 3.56 Should people running genetic services be more involved in commissioning? They have a good understanding of the effect of some disabilities, including among people with less usual needs. Similarly, should appliance services be more closely involved?
- 3.57 Is there enough joining up nationally, between government departments, including the Department for Work and Pensions (DWP), as well as locally and between health and non-health services? For example, local job centres have much expertise through disability employment advisers.
- 3.58 Commissioning for an integrated service is particularly important in the sector of people with disabilities. It should embrace all services more effectively, so that, for example, it includes provision of transport or of appliances. Is that covered?
- 3.59 In this area in particular, while novel solutions will often deliver greater benefits, stability for both provider and user is all important. An annual commissioning round is time consuming and gives no direction; should consideration be given to longer periods, such as three-year rolling contracts?

### Information

- 3.60 In managing information issues, are the following statements correct?
- > Commissioners must be especially sensitive to issues of confidentiality. Even with anonymisation, small groups may be more easily identified.

- > People should be reassured about how the information will be used and that it will be anonymised and, in some circumstances, destroyed after use.
- > Monitoring information should be collected, if possible, as part of a single patient record and should follow the patient through health service and social care services.
- > Management of confidentiality issues should be monitored.

3.61 In presentation of information, are the following statements correct?

- > There should be a wide variety of formats available.
- > Information should be in plain language and be 'friendly looking'; it should have pictures and illustrations. Large fonts and good colour contrasts always help.
- > Information should be multi-layered – directed at disabled people, as well as carers.
- > Most people cannot access non-visual information.
- > For many disabled people, and particularly BME disabled people, it is better to impart information face to face.
- > Disabled people should be involved in drawing up information for the public.

3.62 Do the Department of Health and other government departments need to set standards for PCTs, Health Trusts, Local Authorities and others on better communication? (See Healthcare Commission core standard C16 below.)

## Evaluation

3.63 Do the Healthcare Commission core standards provide a good performance management framework to judge success at a local level, and should a recommendation to use them be included?<sup>28</sup>

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<sup>28</sup> The issue of equality and human rights runs through a number of core standards, such as:

- Core standard C6: Healthcare organisations cooperate with each other and social care organisations to ensure that patients' individual needs are properly managed.
- Core standard C13: Healthcare organisations have systems in place to ensure that staff treat patients, their relatives and carers with dignity and respect.
- Core standard C16: Healthcare organisations make information available to patients and the public on their services, provide patients with suitable and accessible information on the care and treatment they receive and, where appropriate, inform patients on what to expect during treatment, care and aftercare.

## Education and training

- 3.64 In the section on increasing capacity for commissioning, should the guidance point out the need for training in equality and human rights issues, as in the Department of Health paper *Equality and Human Rights in the NHS – A Guide for NHS Boards*, published on 11 December 2006.
- 3.65 There are difficult issues within education and training. As one (blind) informant said: “Clearly there are issues around competencies for current commissioners, particularly for minorities; competencies are least met in social care. But culture may be more important.” So how can training deal with problems in organisational and individual culture?

## Access

- 3.66 Issues go down to an individual level – in terms of access, people who are blind, deaf, physically challenged or who have a learning disability have personally different needs. At the least, commissioners should ensure that premises are fit for purpose and that appropriate transport provision is considered. Are those statements sufficient?

## Conclusion

- 3.67 Is inclusiveness demonstrated in this policy? There is a clear parallel with other equalities issues, and it may be right to consider them in the round, at the same time as keeping individual need very much in mind. As described in paragraph 3.14, is a key success marker for commissioning policy how implementation of the Disability Equality Scheme, together with gender and BME issues, is managed and monitored?

- 
- Core standard C17: The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving healthcare services.
  - Core standard C18: Healthcare organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably.
  - Core Standard C22: Healthcare organisations promote, protect and demonstrably improve the health of the community served and narrow health inequalities.

# Annex A

## Some information on the health and care status of black and minority ethnic communities

### Communities, patients and service users

#### Population:

- > Around 92 per cent of the UK population is white. According to the Office for National Statistics 2001 census data, the UK's population grew by 4 per cent in the 1990s. Some 73 per cent of this growth was due to black and minority ethnic groups, which grew by about 1.6 million people, compared with 600,000 in the white group.
- > Black and minority ethnic groups are considerably more likely to live in England than in the other countries of the UK. In 2001, they made up 9 per cent of the total population of England, compared with only 2 per cent of both Scotland and Wales, and less than 1 per cent of Northern Ireland.

#### Long-term illness:

- > Asian women aged 65 and over had the highest rate of limiting, long-term illness in 2001 (64.5 per cent, compared to 53.1 per cent for all women aged 65 and over).

#### Infant mortality rates:

- > The infant mortality rate for England and Wales in 2003 was 5.2 per 1,000 live births. Babies of mothers born in Pakistan suffered an infant mortality rate of 10.5, more than double the overall infant mortality rate. The second highest infant mortality rate (8.5 per 1,000 live births) was among mothers born in the Caribbean.

#### Gypsies and travellers:

- > This community has a significantly poorer health status and significantly more self-reported symptoms of ill health than other UK residents. At the same time, Gypsies and travellers are less likely than other members of society to visit the GP, practice nurse, health counsellor, chiropodist, dentist, optician or alternative medical workers, or to contact NHS Direct.

#### Mental health:

- > Young black men are six times more likely than their white counterparts to be sectioned under the Mental Health Act for compulsory treatment.
- > There is a higher than average propensity to visit a GP for a nervous or mental health condition among older women of Indian, Pakistani and Bangladeshi origin.

#### Suicide:

- > Young Asian women are more than twice as likely to commit suicide than young white women, according to data reported in 1996.

#### Heart disease:

- > Research on data from the early 1990s indicates that South Asian people are 50 per cent more likely to die prematurely from coronary heart disease than the general population.

#### Stroke:

- > Among African-Caribbean and South Asian men in 2003, the prevalence of stroke was between about 40 per cent and 70 per cent higher than among the general population, depending on age.

#### Diabetes:

- > In 1999, men and women of Pakistani and Bangladeshi origin were more than six times as likely as the general population to have diabetes, and Indian men and women were almost three times as likely. Rates of diabetes among black Caribbean people were also significantly higher than among the general population.

#### Dental health:

- > In 1999, around 90 per cent of children in the general population had visited a dentist. This contrasts with approximately 40 per cent of Bangladeshi and 60 per cent of Pakistani children.

#### Smoking:

- > In 1999, smoking rates were higher among black and minority ethnic men, including black Caribbean men (35 per cent) and white Irish men (39 per cent), and especially Bangladeshi men (44 per cent), compared to 27 per cent of the general population.

#### Obesity:

- > In 2003, 22.2 per cent of men and 23 per cent of women were obese.

- > Women of Caribbean origin are the most likely to be obese – with 50 per cent of those aged 55 or over falling into this category.

**Access to social care:**

- > In 2003/04, 5.0 per cent of adults with completed assessments or reviews were from black and minority ethnic backgrounds.
- > In 2003/04, 4.9 per cent of adults receiving social services were from black and minority ethnic backgrounds.

# Annex B

## Some facts about gender differences in health

- > In most societies, women live longer than men. In England, in 2004, life expectancy at birth was 76.55 years for men and 80.91 years for women. The birth rate for males is higher than for females.
- > In the UK, women use the health services more heavily than do men.
- > Uptake for breast screening is 76 per cent for all women in the UK, but just 17 per cent (family care) and 52 per cent (formal care) for women with learning disabilities; for cervical screening, the rates are 85 per cent (all women aged 20–64), but 3 per cent (family care) and 17 per cent (formal care), respectively.
- > Men are three times more likely than women to commit suicide. But young Asian women are more vulnerable to self harm than their non-Asian counterparts.
- > Women are 2–3 times more likely than men to be affected by depression or anxiety.
- > Death rates from colorectal cancer are 24.7 per 100,000 men, compared to 14.7 per 100,000 women.
- > Men have traditionally smoked more cigarettes and consumed more alcohol than women. In terms of causes of death, men still suffer more lung cancer and chronic liver disease than women. However, smoking rates in adolescent and young women are rising, relative to male smoking rates.
- > Men are more likely than women to die prematurely of heart disease, and men and have higher mortality from injuries and poisoning.

# Annex C

## Some facts about disability

- > Around a third of NHS services users have a disability – that is, people with physical, sensory, learning or psychiatric impairments or some other long-term health problem.
- > The prevalence of disability increases rapidly with age: approximately 75 per cent of men and women aged 85 and over have a disability.
- > Some 20 per cent of people with a disability are under 45.
- > Some 24 per cent of deaf or hearing-impaired people miss appointments, and 19 per cent miss more than five appointments because of poor communication.
- > People with a disability are four times more likely than the general population to find dentists' surgeries inaccessible or inadequate; twice as many as among the population at large find their doctors' surgery inaccessible.
- > Some 40 per cent of visually impaired people believe that their GPs are not fully aware of their needs, rising to 60 per cent for other surgery staff.
- > One study has estimated that people with learning disabilities or long-term mental health problems are 58 per cent more likely to have significant health problems and to die before the age of 50 than people without disability. In primary care, both groups are less likely to receive evidence-based health checks and treatment than other patients.

## From the Disability Rights Commission (DRC) website

- > The DRC's Health Formal Investigation has found that people with a learning disability or mental health condition are far more likely to have diabetes, respiratory illness, coronary heart disease and other heart conditions. This makes participation harder for these already excluded groups.
- > There is a much higher rate of obesity among people with learning disabilities (35 per cent, compared with a general population figure of 22 per cent). The figure for women with learning disabilities is particularly high at 40 per cent.

- > Over 60 per cent of people with serious mental health conditions smoke. Providing the right support for them to quit could play a significant part in helping government achieve its target of reducing the proportion of the British public who smoke from 28 per cent to 24 per cent by 2010.
- > People with learning disabilities, especially more severe learning disabilities, have much lower rates of cervical screening, mammography and other routine tests than other citizens.
- > GPs can play a central role in supporting people who develop an impairment or health condition in work to keep their job. After 28 weeks out of work, the chance of the person ever working again plummets.
- > Some groups – those in institutions, homeless people and some ethnic minority communities – are especially unlikely to get high-quality healthcare.

# DH Proforma – Equality Impact Assessment Screening

## Policy

Commissioning Framework for Health and Well-being

## Policy area/section

Overall

## Questions

**Qu 1.** What is the overall purpose of the proposed policy area?

The commissioning framework for health and well-being is intended to cover:

- > health and well-being for all ages and care groups
- > joint commissioning between health and local government
- > services for people with long-term conditions
- > social care
- > mental health
- > non-GMS primary and community services
- > the engagement and participation of third sector organisations

**Qu 2.** What is the proposed policy area aiming to achieve?

The commissioning framework takes as its starting point the reduction in inequalities and the promotion of equality by a) improving the delivery of integrated and coordinated services to individuals, and b) improving the health and well-being of individuals and communities.

**Qu 3.** Who is expected to benefit from the proposed amendment?

All ages and care groups

**Qu 4.** Are there any related policy areas that may be affected by changes in this policy (or section)?

- > Choice
- > Finance
- > Primary and community care models of provision
- > Commissioning acute services
- > Performance management

**Qu 5.** Screening questions

Answer yes, no or not sure/don't know for each question, and put a short summary or list of reasons in each case.

<p><b>Qu 5.a)</b> Do different groups have different needs, experiences, issues and priorities in relation to the proposed policy?</p> <p>Yes, there are different social justice and health issues for different groups.</p>
<p><b>Qu 5.b)</b> Is there any evidence, or potential for suggesting, that the proposed policy will promote equality of opportunity for all and promote good relations between different groups?</p> <p>Yes, the whole intention of the policy is to reduce inequalities and promote equality.</p>
<p><b>Qu 5.c)</b> Is there any evidence, or potential for suggesting, that the proposed policy will affect different population groups differently (including possibly discriminating against certain groups)?</p> <p>Yes, although the intention of the policy is to produce intelligent partnerships that manage this problem.</p>
<p><b>Qu 5.d)</b> Is there public concern (including media, academic, voluntary or sector-specific interest) in the policy area about actual, perceived or potential discrimination against a particular population group or groups?</p> <p>No, except for existing issues of discrimination, which this policy aims to correct. This is a new policy, which should address health outcomes for groups with potential (inadvertent) discrimination problems, while improving or maintaining social justice.</p>
<p><b>Qu 5.e)</b> Is there doubt about answers to any of the above questions (for instance, there may not be enough information to draw a conclusion)?</p> <p>No, the policy is very comprehensive. It is still under development, so</p>

there are still opportunities to shape it and provide greater certainty that it will fulfil the aims outlined in the answer to question 2 above.

### Scoping Questions

**Qu 6.** What evidence have you used to support the conclusions drawn in screening questions 5a–5e?

This evidence is drawn from:

- > policy documents
- > research-based literature
- > information from voluntary and special interest groups
- > expert opinion from policymakers, leaders in patient empowerment, inequalities issues, public health, social care, practitioners in the NHS

**Qu 7.** What is the strength of this evidence – for instance:

- > well established and validated?
- > strong evidence, but a few gaps?
- > some evidence, but considerable gaps?
- > anecdotal?

Largely well established and validated.

**Qu 8.** If the evidence is not sufficient, what other information is needed?

N/A

**Qu 9.** In particular, are there people who may be affected by the policy area, whose views and experiences should be sought?

Yes. It is not possible or appropriate to consult with the whole of the diverse groups that this policy is intended to address, but it is possible to speak to advocates for many of those groups. This process has already begun in the screening process and in drafting the consultation document – for example, testing with the DRC.

**Qu 10.** Does the policy area:

**Yes/ No**

- > affect a large number of people (for instance, does it cover service provision such as primary care)?
- > have risks *or* potential attached to its implementation/ delivery in relation to equality because, for instance, it

Yes

<p>relates to:</p> <ul style="list-style-type: none"> <li>– strategies or services specific to a particular group, like older people, pregnant women or mental health services for deaf people?</li> <li>– or to a disease or service area where a disproportionate number of some population groups are affected, such as Coronary Heart Disease, HIV or ophthalmic services)?</li> </ul>	<p>Yes</p>
	<p>Yes</p>

**Qu 11.** What is the *probability* of adverse or beneficial effects?

> Risk of adverse effects on equality (indicate one)

<p>Highly likely to have adverse effect on equality <i>High risk</i></p>	<p><del>May possibly have adverse effect</del> <i>Moderate risk</i></p>	<p>Probably will not have adverse effect <i>Low risk</i></p>
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> Potential for benefit (indicate one)

<p>Highly likely to promote equality of opportunity and good relations <i>High potential (low risk)</i></p>	<p><del>May have the potential to promote equality and good relations</del> <i>Moderate potential (moderate risk)</i></p>	<p><del>Probably will not promote equality or good relations</del> <i>Low potential (high risk)</i></p>
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**Qu 12.** If the risks came to pass, how substantial would these be (in terms of the number of people affected and the severity of the problem)?

<p>Lots of people from different groups may be affected to some extent</p>	<p><del>A few people may be adversely affected to some extent</del></p>
<p><del>A few people may be affected, but the effect on them will be highly adverse</del></p>	<p><del>A lot of people may be severely affected</del></p>

**Qu 13.** Based on your discussions, note down the next steps required to complete an impact assessment, including any comments on time, resources, and technical or other support that may be needed. Consider what the questions are that still need to be answered, for example:

- > the current situation
- > differential effects of the proposals on particular groups – scale, nature, risk

- > the views and experiences of particular interested parties
- > workable solutions for problems identified
- > monitoring that will be needed
- > how the findings will be consulted on, published and disseminated

The current situation is one of substantial health inequalities and problems with social justice, which this policy aims to ameliorate for all groups. There is no simple measure of the differential effects – but we know that certain subgroups within BME populations have particularly poor health and social status, such as middle-aged Bengali women or the children of South Asian families, where childhood disability is three times the level of the corresponding white group. Equally, different groups that may have different disabilities, such as people with mental health problems or learning disabilities, may have issues with access or provision of healthcare. Gender issues are already familiar in some ways to commissioners, but not as an overarching theme, and this should be addressed.

Consultation, described below, should take account of as many different client groups or their representatives as possible. Workable solutions are the whole objective of the policy. Overall, in order for the policy to be successful, a number of measures should be undertaken, including:

- > accurate ethnic monitoring, using widely accepted coding
- > seeking out different groups and individuals
- > addressing access issues
- > differential application of policy to different groups and individuals
- > extra resources devoted to addressing differential need or hard-to-reach populations or individuals
- > extra training for health professionals and managers
- > development of appropriate standards
- > inspection and continuing evaluation

In the three-month consultation on the whole policy, for these aspects the Department of Health might wish to employ:

- > good communication approaches
- > specific questions
- > web-based questionnaires
- > knowledge of good existing practice in the NHS

- > health equity audits
- > expert groups
- > voluntary sector experts
- > users and carers from the different groups

For further details on the consultation, please go to <http://www.commissioning.csip.org>