Department of Health

Single Equality Scheme 2006–09

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December 2006

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Foreword from the Secretary of State and the Permanent Secretary

The Department of Health is responsible for improving the health and well-being of everyone in England. As we continue our reform of the whole system of health and social care towards services that are led by patients and service users and where services work with people to support them with their health and social care needs, it is important now more than ever that we ensure that the needs of everyone in the population are met.

To support us in achieving this, this Single Equality Scheme heralds a change in the way in which we at the Department of Health think about and deliver our work. It sets out our commitment to equality, and our determination to ensure that the Department's policies and practices meet the needs of all our staff as well as all of those who use the NHS and social care services.

The Single Equality Scheme sets out how the Department will meet its obligations under equality legislation over the next three years, but more than that, how it will make a real and positive difference to the lives of all those who are affected by what we do. Only by ensuring that we systematically set out how we are going to do this – and hold ourselves to account for our delivery – can we make the differences we all want to see.

Patricia Hewitt
Secretary of State for Health

Hugh Taylor

Hugh Taylor
Acting Permanent Secretary

Executive summary

This Scheme sets out the way in which the Department of Health (DH) intends to meet its duties under the Race Relations Amendment Act 2000, the Disability Discrimination Act 2005 and the Sex Discrimination Act as amended by the Equality Act 2006. The Department of Health will also progress action on religion or belief, sexual orientation and age. Action relevant to each strand is highlighted in the action plan at Appendix 5.

In producing this Scheme, we have allowed time for us to gather views, and involve people in discussing how it might be improved, and the action plan prioritised before it is finalised in April 2007.

In line with the disability duty, disabled people were involved in the development of the Scheme through a day-long workshop and their views informed both the Scheme and the action plan. As we further develop and put this Scheme into effect, we intend to build in the involvement of disabled people at every stage, including monitoring the action plan.

The implementation of this Scheme will be monitored within mainstream business planning processes. The National Director for Equality and Human Rights, Surinder Sharma, will report on progress to the Permanent Secretary and the lead Minister of State for Health with responsibility for Equality and Human Rights, the Departmental Management Board and Corporate Management Committee on a six-monthly basis. The Secretary of State will publish a report on the Disability aspect of the Scheme on a three-yearly basis and make proposals for co-ordination of future work.

This Scheme outlines how DH will address the various aspects of the three duties specified in the legislation. This includes the way in which DH will conduct its equality impact assessments (EqIAs). Information gathering to support EqIAs will include monitoring data, consultation processes and research. Assessments will be made at an early stage of – and will inform – policy development. When considering the impact on disabled people in particular DH will consider impact in terms of the full range of disabilities. If assessments show that the policy has the potential to affect particular groups of people in a way that disadvantages them, then the policy will be amended where possible. In terms of disability, it may be necessary to think of 'reasonable adjustments' which would enable disabled service users or staff to access services and opportunities. It may also be necessary to make provision for alternative services.

The Scheme also includes action on access to information. DH has a policy of openness and transparency. We will publish and release all information, use language appropriate to the intended audience and ensure our information is available in accessible formats. While maintaining this principle of inclusivity and accessibility with public-facing campaigns and publicity, this does not preclude the need for local communicators to address specific needs, such as language.

The way DH engages with its stakeholders (including different communities) will be improved. Consultation is an essential part of assessing the impact of new policies, and DH is undertaking actions to ensure that robust consultative mechanisms will enable policy makers to collect the relevant information and viewpoints. The action plan outlines a series of specific actions on involvement.

The Scheme addresses the way harassment and bullying are dealt with within DH. Existing policies specifically refer to disability.

Monitoring is an essential tool for ensuring that there is no disproportionality in the way services are accessed. Much of the action DH will be taking in the next three years includes the development of improved data gathering on all the equality strands as well as improved methods for analysing data and acting upon the information received.

DH will train its staff in the implementation of the equality duties. In terms of employment of departmental staff, the Civil Service 10-Point Plan (see Appendix 3) will be reviewed and progressed. This is a Cabinet Office-led initiative published in November 2005 to improve the representation of women, black and minority ethnic staff, and disabled staff in the Senior Civil Service with targets set for 2008. In addition, a series of measures will be taken to improve the representation and experience of different groups of staff at all levels of the organisation. DH will be conducting an equal pay audit, looking at ethnicity, gender and disability. An action plan will be drawn up to address any disparity in pay.

Other key actions that will be taken by DH include looking at the equality implications of the Public Service Agreement (PSA) targets and EqIAs on the main programmes being undertaken by the Department of Health.

Purpose of the Single Equality Scheme

The purpose of this Scheme is to set out the way in which the Department of Health (DH) will meet its duties under the Race Relations Amendment Act 2000, the Disability Discrimination Act 2005 and the Sex Discrimination Act as amended by the Equality Act 2006 over the next three years. The aim is to develop measures and actions that ensure discrimination on the grounds of race, disability and gender does not occur and to positively promote equality.

An equality scheme is a plan that outlines a public authority's action over three years, aiming to address aspects of the general duty as outlined in equality legislation. The general duty is a positive duty that builds equality into the beginning of the process of policy making rather than making adjustments at the end of the process. It represents a change from a legal framework where the onus is on the individual to bring a complaint of discrimination to one where the onus is on the public sector to seek out actual or potential discrimination and address it.

The Government is bringing together the three existing statutory equality commissions (Commission for Racial Equality [CRE], Equal Opportunities Commission [EOC] and Disability Rights Commission [DRC]) to create a Commission on Equality and Human Rights that will, from October 2007, cover all equality strands (sexual orientation, religion and belief, and age in addition to race, gender, disability) and human rights. The Government is also undertaking a review of equality legislation and plans to introduce a Single Equality Bill in autumn 2007 that will cover all the traditional strands of equality. In addition to these governmental measures, DH recognises that each individual will have different needs that will influence their health and social care requirements. For all these reasons, DH has produced this Single Equality Scheme that includes race, disability and gender and has, where possible, addressed action to eliminate discrimination on the grounds of age, religion or belief, or sexual orientation.

The Scheme was developed by DH's Equality and Human Rights Group with the rest of DH. Material used includes the updated Race Equality Scheme (2005), information and action agreed with the DRC under the Framework for Partnership Action, and various DH documents such as those on monitoring ethnicity and on monitoring sexual orientation. The action plan was drawn up based on research data held by DH and following (three day-long) workshops with policy leads and (one workshop) with senior managers (branch heads).

Involvement of disabled people

Disabled people were involved in the development of the Scheme through a day-long workshop and their views informed the Scheme and its action plan. (See Appendix 1 for a summary report of this workshop.) Disabled staff attended some of the policy leads' workshops. We intend to capture more views from disabled people and disability organisations as we continue to develop the Scheme.

Comments on the Single Equality Scheme

This is a living document. We have drawn up this Scheme with the information we have to date; as more information becomes available, we will update the Scheme. Furthermore, the Department of Health (DH) is not a static organisation. Any changes to our remit or targets will be reflected in changes to the Scheme as required. We also recognise that there is a tremendous amount of expertise both in DH itself, and in the wider community. We therefore invite your comments so that we can refine and develop the Scheme with a view to launching a revised version in spring 2007. We would be grateful if these could be received by 9 March 2007.

In line with the Department of Health's policy of openness, copies of the responses we receive may be made publicly available through the DH website. If you do not consent to this, you must clearly request that your response be treated as confidential. Any confidentiality disclaimer generated by your IT system for an email response will not be treated as such a request. You should also be aware that there might be circumstances in which the Department of Health will be required to communicate information to third parties on request, in order to comply with its obligations under the Freedom of Information Act 2000.

Please send comments to:
Equality and Human Rights Group (SES)
Room 692D
Skipton House
80 London Road
Elephant and Castle
London SE1 6LH
Email: singleequalityscheme@dh.gsi.gov.uk

1. Background and context setting

1.1 The Department of Health's goals

The Department of Health's (DH) overall aim is to improve the health and well-being of the population of England. We do this by leading and supporting NHS and social care organisations so they can provide fair, high-quality services that offer real choice for patients as well as best value for taxpayers.

The shape of DH is changing to help us improve the way we manage our workload, make key decisions and meet our top priorities. Our business planning and priority setting will be informed by the need to ensure that we meet the Government's vision for equality, including robust assessment of the relevance of equality issues to our core functions. The DH's Business Plan for 2007/08, setting out our vision and values, will be published shortly.

DH currently has seven high-level goals. These are:

1. To lead sustained improvements in public health and well-being, with specific attention to the needs of disadvantaged and vulnerable people.
2. To enhance the quality and safety of health and social care services, providing faster access and better patient and user choice and control.
3. To deliver an improved care experience for patients and users, including those with long term conditions.
4. To improve the capacity, capability and efficiency of the health and social care system.
5. To ensure systems reform, service modernisation, IT investment and new staff contracts deliver improved quality and value for money.
6. To improve the service we provide as a department of state to – and on behalf of – ministers and the public, nationally and internationally.
7. To develop departmental capability and efficiency and cement our reputation as an organisation that it is good to do business with and a good place to work.

Equality and human rights principles are threaded throughout these priorities. Our staff are responsible for leading and driving forward change in the NHS and social care, as well as improving standards in public health. DH ensures new policies are developed in collaboration with patients, communities, health and social care staff, the voluntary sector and other government departments. DH has around 2,300 staff, based mainly in London and in Leeds.

The DH Change Programme identified work with stakeholders as a priority for improvement. The DH Forward Plan commits us to strengthening our engagement with external stakeholders, learning from our successes, spreading best practice across DH, developing new models for managing stakeholder relationships, and supporting new ways of working that will embed a more collaborative approach to policy making.

The Stakeholder and Relationships Partnership Team has been established to support colleagues responsible for developing and delivering policy to be efficient and effective in building strong, sustainable and purposeful stakeholder relations through developing business processes that add value; supporting the fostering of an appropriate culture and behaviours; and promoting appropriate governance arrangements.

DH is accountable through ministers and Parliament and the public for the overall performance of the NHS, adult social care, and the work of DH itself.

1.2 The Equality and Human Rights Group

The Equality and Human Rights Group is the central team in DH led by Surinder Sharma, National Director for Equality and Human Rights, with a remit to give strategic focus, leadership and co-ordination for achieving corporate delivery of equality and human rights across DH and to drive implementation in the NHS and social care. Its work includes identifying and analysing population trends and variations in relation to age, disability, gender, race, religion or belief, or sexual orientation and how these impact on patients; embedding equality in policy making, programmes and communication by developing equality impact assessment tools and ensuring that equality is embedded in NHS and social care procurement and commissioning.

1.3 Issues and action concerning the different equality strands

This section highlights a few of the health issues we know need to be addressed as well as some of the action already being taken by DH.

Race

Issues of race have been tackled, in particular through action outlined in the first and second Department of Health Race Equality Schemes published in 2002 and 2005.

Issues

There are significant differences between the health of the general population and the health of black and minority ethnic groups (BME). For example:

- People from many BME groups tend to have worse health than the wider population.
- Infant mortality is higher for children with mothers born in Pakistan and mothers born in the Caribbean.
- Gypsies and travellers have significantly poorer health status. They are less likely to visit GPs, practice nurses, dentists or contact NHS direct, and have a significantly lower life expectancy than the wider population.
- Smoking rates are higher among BME men.
- The prevalence of stroke is much higher among African-Caribbean and South Asian men.
- BME communities are among the least satisfied with the services they receive.
- Coronary heart disease is more common among South Asians.
- The incidence of diabetes is five times higher among South Asians and three times higher among those of Caribbean backgrounds than in the general population.
- Incidences of mental illness are higher in some BME communities.
- Young Asian women are twice as likely to commit suicide than are young white women.

Action

In response to these issues, DH is taking action on a number of fronts including:

- Raising the quality of data on the health needs and experiences of people from BME groups.
- The Government has a target to narrow the gap between the population as a whole and the fifth of areas with the worst health and deprivation indicators. This fifth represents the Spearhead Group and includes 44 per cent of the total BME population in England.
- Heart disease among South Asians.
- Smoking (leaflets, posters, information booklets, and a helpline with counsellors who speak community languages) is being targeted at BME groups (particularly Bangladeshi and Pakistani communities).
- Diabetes among BME groups.
- Cancer screening for Asian women is being targeted.
- An organ donation campaign for BME groups is being run and includes leaflets in community languages.

- ‘Count me in’, a census of the ethnicity, language and religion of mental health inpatients was first carried out in March 2005 and is now an annual programme.
- An action plan on mental health is being implemented.
- The Leadership and Race Equality Programme, which gives greater prominence to race equality in the NHS, is being implemented.
- DH has produced a fact sheet to explain the role of UK health services to newly arrived individuals seeking asylum.
- As part of the foundation trust application process, all NHS trusts are required to demonstrate that their governance arrangements have included ethnic minority and hard-to-reach groups.
- Many Regional Public Health Groups have supported innovative projects such as Bangladeshi Breast Awareness in Northamptonshire and Newark, and Sherwood Primary Care Trust’s work with travellers to design services and improve access.

Disability

Issues

Definitions of disability vary and many people do not consider themselves to be disabled, claim disability-related benefits or use the services that can support them.

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 the figures at 11 million disabled adults and 770,000 disabled children in the UK. These few examples show why achieving equality for disabled people is so important:

- The prevalence of disability increases rapidly with age, approximately 75 per cent of men and women aged 85 and over have a disability.
- Twenty per cent of those with a disability are under age 45.
- Twenty-four per cent of deaf or hearing-impaired people miss appointments, and 19 per cent miss more than five appointments because of poor communication.
- Disabled people are four times more likely than the general population to find dentists’ offices inaccessible or inadequate; twice as many find their doctors’ surgery inaccessible.
- Forty 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 die before the age of 50 than non-disabled people.

Whatever definitions or numbers we choose to use, it is an inescapable fact that disabled people make up a significant proportion of our population, and disabled people need to make greater use of and have access to health services than non-disabled people. Around a third of NHS services users are disabled – that is, people with a physical, sensory, learning or psychiatric condition or other long-term health conditions. Disabled people expect the assistance and support that the NHS and social care can provide, and for those services to be provided on an equitable basis.

Improving Life Chances states that, by 2025, disabled people should have full opportunities and choices to improve their quality of life, be respected and included as equal members of society. The report makes recommendations across four key areas: independent living, early years and family support, transition to adulthood and employment.

The Office for Disability Issues (ODI) was set up in response to a recommendation in *Improving Life Chances* to tackle a lack of co-ordination between government departments in the way policy is developed and services are delivered for disabled people, and to identify and work towards tackling gaps in policies and services, and conflicts between policies in different departments.

Improving Life Chances also recommends establishing a national forum for organisations of disabled people, to enable disabled people to communicate directly with government. An advisory group made recommendations about the role and design of this forum, now called Equality 2025. The membership of Equality 2025 will be announced by the ODI shortly.

The Government's commitment to improving the life chances of people with learning disabilities was set out in the *Valuing People: A New Strategy for Learning Disability for the 21st Century* White Paper (March 2001). This cross-government paper was the first White Paper for people with learning disabilities for 30 years and is based on the four key principles of rights, independence, choice and inclusion.

Two funds support the programme of work set out in *Valuing People* – the Implementation Support Fund and the Learning Disability Development Fund.

The Disability Rights Commission (DRC) published its formal investigation into physical health inequalities experienced by people with learning disabilities and/or mental health problems on 14 September 2006. The investigation confirmed that people with a learning disability and mental illness are much more likely to have significant health problems than the rest of the population. Both groups are likely to die younger than other people. In primary care, both groups are less likely to receive some of the evidence-based checks and treatments than other patients.

Action

DH is leading on, or participating in, action on a number of fronts to tackle these issues as follows.

Several key government programmes are contributing to the delivery of the DH aspects of the *Improving Life Chances* report:

- **Independent living.** This is a focal area of work for DH and implementation of this is being taken forward through the work on the *Our health, our care, our say* White Paper. However, the ODI is leading a review of independent living through a multi-discipline, cross-government project team, working with an expert independent living panel, to develop a set of proposals for successful delivery of the aspirations and recommendations of Chapter 4 of the *Improving Life Chances* report. DH is contributing to the work of the review.
- **Early years and family support.** The Department for Education and Skills is the lead department in delivering on this through the Change for Children programme; however, DH has a particular interest from the health perspective, particularly linking with the National Service Framework for Children's standard for disabled children and their families.
- **Employment.** Overall this is a Department for Work and Pensions lead; however, DH is engaged closely through our joint Health, Work and Well-being strategy.

The basic framework to ensure delivery of *Valuing People* includes:

- **The Learning Disabilities Taskforce.** This is a national body to oversee delivery of *Valuing People*, bringing together representatives from across government and experts from learning disability organisations, including people with learning disabilities and their carers.
- **Learning Disability Partnership Boards.** These are led by local councils with membership from social and health services, housing, education, service users, carers and other partner organisations.
- **The Valuing People Support Team.** This is a team of regional and national advisers working within the Care Services Improvement Partnership to lead implementation of the strategy.

DH will respond in detail to the DRC's formal investigation in early 2007.

DH and the DRC have agreed a partnership framework that identifies key priority areas for partnership working and joint action to improve the rights, independence, choice and inclusion of disabled people through ongoing development of the health and social care system. Implementation and steering of the framework is undertaken by the DH/DRC Disability Partnership Forum. A Disability Partnership Action Group steers progress on the joint work programme.

Guidance for policy makers has been developed jointly with the DRC ('Promoting disability equality in policy making to support national priorities for health and social care') and is available to all DH staff on the internal website.

Joint DH/DRC guides have been published for acute trusts and primary care trusts on the Disability Discrimination Act and how to make a difference to the experiences of disabled people using health services.

Eleven pilots have been chosen to test self-assessment, allowing people with long-term health and social care needs to assess their own support requirements and apply directly for services to help them.

In addition, DH is working towards supporting disabled people to make informed choices and to access the services they need thus promoting greater participation by disabled service users, carers and the wider disabled community in influencing service design and delivery.

Specific actions are set out in the Single Equality Scheme Action Plan at Appendix 5.

Gender

Issues

The differences between men and women in health status and use of services are significant. These differences also result from differences in income and social class, age, ethnicity and caring responsibilities. For example:

- Men are three times more likely than women to commit suicide.
- Women are between two and three times more likely than men to be affected by depression or anxiety.
- Death rates for 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 and there are important differences in the numbers of deaths from lung cancer and chronic liver disease between women and men.

Action

The forthcoming Gender Equality Duty provides DH with the opportunity to ensure our key health strategies take account of gender inequalities and differences in health issues experienced by men and women. As an employer, DH will ensure issues of equal pay are addressed in consultation with all staff.

In preparation for the implementation of the Gender Equality Duty in April 2007, the Equality and Human Rights Group will be working with DH policy teams to identify where action to address gender inequalities can be taken. This work will also be informed through consultation with key stakeholders and specialist gender equality interest groups and the Equal Opportunities Commission, through the development of a Gender and Health Partnership Forum in early 2007.

More details of action that DH will take to meet the requirements of the Gender Equality Duty will be contained in the fully reviewed Single Equality Scheme in April 2007.

Religion or belief

Issues

DH recognises that we all now live in a multi-cultural, multi-faith society. DH is committed to recognising the needs of patients and staff of diverse religious groups, and to responding sensitively and appropriately to their needs. The NHS Plan, published in July 2000, signals that a key part of reforming the NHS and social services is the need to ensure the delivery of fair, appropriate and equitable access to services for all. The NHS and social services must take account of the personal needs (such as religious, cultural, dietary and language requirements) of the multi-cultural and spiritually diverse communities it serves by ensuring that all services are delivered appropriately to all service users and staff.

As part of DH's overall aim of improving the health and well-being of the population, we aim to reduce health inequalities and deliver services that are responsive to the needs of faith communities. DH leads on the Government's national Public Service Agreement (PSA) health inequalities target on life expectancy, which aims to narrow the gap between the population as a whole and the 'fifth of areas with the worst health and deprivation indicators'. This is the Spearhead Group of areas that contain 70 local authorities mapped to 88 primary care trusts (PCTs), covering 44 per cent of the total black and minority ethnic population.

Despite containing only 31 per cent of the population of England, the 88 PCTs that make up the Spearhead Group contain 53 per cent of the Muslim population of England.

Muslims are not a homogeneous group for health status, disease patterns or health behaviours. However, although disease prevalence and access to services has not been monitored by religion, there is evidence to suggest that large sections within Muslim communities experience significant health inequalities. This is based on knowledge of health outcomes for Pakistani and Bangladeshi communities.

Action

DH has funded and continues to fund voluntary and faith organisations and places of worship to develop their capacity to provide health services to their local communities.

Some areas funded by DH include:

- The prevention or management of cancer, coronary heart disease, diabetes and mental illness – preventative screening on site in partnership with local health promotion units, as well as dietary and nutrition advice classes for the local population. These organisations arrange seminars, health fairs and produce leaflets to promote health messages in community languages.
- A range of educational, health and social welfare activities, the provision of support and advice on general and health-related issues.

DH is targeting action on specific issues, including:

- heart disease among South Asians;
- smoking among BME groups, particularly the Bangladeshi and Pakistani communities, including a successful tobacco education campaign targeting Muslims during the month of Ramadan;
- diabetes among BME groups;
- cancer screening for Asian women; and
- organ donation campaign for ethnic minorities.

Ramadan provides a key opportunity for culturally specific promotion of DH's public health agenda among a key target group. DH funded Communities in Action to produce a *Ramadan Health and Spirituality Guide* which was launched on 22 September 2006 and distributed to the fasting Muslim population, so that they could reduce potential health risks while maximising the benefits of the fast. It includes complementary information for health practitioners, including a practical guide to offering more inclusive health provisions for the fasting population.

Sexual orientation and gender identity

Issues

Many lesbian, gay, bisexual and transgender (LGBT) people face discrimination in today's society. The experience of homophobia, transphobia and heterosexism can have a serious health impact, especially on young people. Sexual orientation and gender identity undoubtedly contribute to health inequalities and poor experience of health services. There is limited substantive guidance in England covering the health of LGBT people, their experience of health services and their quality of life. However, studies have shown that:

- access to gender reassignment services is haphazard and provision of generalised health care is patchy and inadequate;
- 77 per cent of LGB young people experience homophobia in schools;
- 66 per cent of LGBT people have been a victim of homophobia;
- 41–44 per cent of gay men have not disclosed their sexuality to their GP;
- LGB individuals have higher levels of mental ill health than their heterosexual counterparts;
- older LGB people are five times less likely to access services for older people than is the case in the general older population, because they fear discrimination, homophobia and ignorance.

Action

DH is committed to eliminating discrimination and promoting equality for LGBT people in health and social care (as both service users and employees). We are working with external LGBT stakeholders on the development and implementation of a sexual orientation and gender identity equality strategy. A Sexual Orientation and Gender Identity Advisory Group is assisting with this work. Work is being taken forward through four workstreams: transgender health, better employment, inclusive services and health inequalities.

As part of this strategy, a number of resources were commissioned and published earlier this year including three Stonewall Reports on *Harassment and Sexual Orientation in the Health Sector*, *Reducing Health Inequalities for Lesbian, Gay and Bisexual People: Evidence of Health Care Needs*, and *Monitoring Sexual Orientation in the Health Sector*. A DVD resource, *Real Stories, Real lives: LGB and T people and the NHS*, was also produced to support healthcare organisations in developing strategies to promote equality and eliminate discrimination for LGBT people. All of these resources are available on the sexual orientation and gender identity pages on the DH website at: www.dh.gov.uk/EqualityAndHumanRights.

DH will develop actions by March 2007 to specifically address the needs of transgender people. Work being funded in 2006/07 includes:

- a research project to map existing models for provision of services to people undergoing gender reassignment;

- an audit of the treatment experiences and outcomes of people who have undergone gender reassignment; and
- the development of educational and advice leaflets for transgender people and health professionals.

In addition to the above, s64 grants[1] target older people, disabled people and BME groups; 54 per cent of grants on cancer programmes are on equality issues.

Further work is currently underway – full details of the programme will shortly be published on the DH website.

Age

Issues

There is a great deal of anecdotal evidence of negative attitudes from healthcare providers towards older people that affect the quality of service they receive. Specific examples of inequalities experienced by older people include:

- Older people make up 62 per cent of social services' clients, but only 47 per cent of the budget is spent on them.
- More people report experiencing age discrimination than any other form of discrimination.
- Those aged 65 and over constitute one-sixth of the population and yet occupy two-thirds of general and acute beds.

Action

The National Service Framework (NSF) for Older People was launched in March 2001 and set national standards to improve services for older people, at home, in residential care and in hospital. The aim of the NSF is to root out age discrimination. Since then, the number of hip replacements carried out on people aged between 65 and 74 has increased by 39 per cent, and for people 75 years or older, it has increased by 22 per cent. Breast screening of over 65s has more than doubled.

In addition to this, DH launched its Dignity in Care campaign in November 2006 to place dignity and respect at the heart of caring for older people. This was backed by a £67million grant to improve the environment of care homes across the country.

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[1] The Secretary of State has the power, through section 64 of the Health Services and Public Health Act 1968, to make grants to voluntary organisations in England whose activities support the Department of Health's policy priorities.

The NSF for Children was launched in September 2004 and has a very broad remit, setting standards for the whole range of health and social care issues for children and young people, as well as for the interface of those services with education. The overall aim of the Children's NSF is to drive up the quality of services provided to children, young people and pregnant women, promote health improvement and address health inequalities.

1.4 The legal background to a Single Equality Scheme

This section summarises the three general duties that underpin the Single Equality Scheme.

Race Relations Amendment Act 2000: Race General Duty

DH has a statutory duty to promote race equality with due regard to the need to:

- eliminate unlawful discrimination;
- promote equality of opportunity; and
- promote good relations between people of different racial groups.

Disability Discrimination Act 2005: Disability General Duty

DH has a statutory duty to carry out its functions with due regard to the need to:

- promote equality of opportunity between disabled people and other people;
- eliminate discrimination that is unlawful under the Disability Discrimination Act;
- eliminate harassment of disabled people that is related to their disability;
- promote positive attitudes towards disabled people;
- encourage participation by disabled people in public life; and
- take steps to meet disabled people's needs, even if this requires treatment that is more favourable.

The DRC 2006 guidance 'The Disability Equality Duty: Guidance on gathering and analysing evidence to inform action' advises that work on disability should follow the 'social model' of disability as opposed to the 'medical model'. The key difference between the two is in the 'location' of the problem. According to the medical model, disabled people are unable to participate in society as a direct result of their disability. In the social model, people are disabled by physical and social barriers. The general duty aims to understand and dismantle these barriers.

Sex Discrimination Act as amended by the Equality Act 2006: Gender General Duty

When this comes into effect on 6 April 2007, DH will have a statutory duty to promote gender equality with due regard to the need to:

- eliminate unlawful sex discrimination; and
- promote equality of opportunity between women and men.

In addition to each general duty, there are specific duties that outline the manner in which the general duty is to be implemented. All the specific duties have informed the structure of this Single Equality Scheme.

The duties apply to services, employment, policy development, procurement, performance management, organisational design and delivery, and any other departmental activity that is not explicitly exempt from the Acts.

In addition to addressing the general duties as outlined above, DH will progress action on religion or belief, sexual orientation and age. Although there is no legal protection covering these strands, there is a need to address discrimination; current legislation covers employment and service delivery (except for age, where only employment is covered).

Action relevant to each strand is highlighted in the action plan.

1.5 Responsibility for the Single Equality Scheme

The Secretary of State, supported by the Permanent Secretary and the DH Management Board, is responsible for ensuring the implementation of this scheme.

Each DH Director General is responsible for ensuring that their business area delivers the action plan. Directorates are to report to the Policy Committee on key programmes contributing to equality. From November 2006, there will be a report on equality and diversity to the DH's Corporate Management Board every three months.

All staff are responsible for delivering the scheme as it relates to their area of work.

1.6 Review of the Single Equality Scheme

The implementation of this scheme will be monitored within mainstream business planning processes.

The National Director for Equality and Human Rights will report progress to the Permanent Secretary and the lead Minister of State for Health for Equality and Human Rights, the Departmental Management Board and Corporate Management Committee on at least a six-monthly basis.

The Secretary of State will publish a report on the disability aspect of the scheme on a three-yearly basis and make proposals for co-ordination of future work.

2. How the Department of Health will meet the equality duties

2.1 Equality impact assessments

The Department of Health (DH) is committed to ensuring that all individuals and population groups should have equal opportunity to benefit from our policies. We know, however, that inequalities in health persist across the equality spectrum, whether related to a person's age, disability, gender, race, religion or beliefs, or sexual orientation. It is important that we ensure that our policies are capable of delivering the changes required to address these inequalities, not only to achieve our aim of improving the health of the whole population, but also to meet our legal obligations. DH is adopting an integrated approach to testing assumptions about the potential effects of emergent policy by using impact assessment methodology. By assessing the potential effects of a policy on particular populations in a rigorous way, we can increase the probability that a policy will promote equality of outcomes.

DH has made available to staff up-to-date guidance and a tool for undertaking equality impact assessment (EqIA). This can be found in Appendix 2. The guidance leads policy makers through a screening process to establish which aspects of an emergent policy might be subject to impact assessment. The impact assessment process itself is designed to enable policy makers to determine: the strength of the existing evidence base to support the proposed policy option and its likely impact on different population groups; what further information might be required to form a judgement on its suitability and relevance; what adjustments might be needed; and how it is going to be monitored to ensure that it has delivered the desired outcome.

DH's processes and systems are being revised to ensure that policy development follows a robust procedure based on equality to deliver better outcomes.

2.2 Access to information

DH has a policy of openness and transparency. We will publish and release all information, use language appropriate to the intended audience and ensure that our information is available in accessible formats. While maintaining this principle of inclusivity and accessibility with public-facing campaigns and publicity, this does not preclude the need for local communicators to address specific needs, such as language. Standard information leaflets will make it clear who to contact to get information in different formats. We will ensure that requests for this can be made in various ways and not just by telephone, thus ensuring that those who have a hearing impairment can contact us. Information will be produced in plain English, with illustrations and good colour contrast. This will also apply to campaigns and leaflets aimed at the public. When producing DVDs we will ensure that they are subtitled or signed. Information will be disseminated, wherever possible, through front-line staff and therefore given to patients and users face to face. DH will set standards for communications for health trusts and primary care trusts (PCTs). We will consider producing as much information for the public as possible in 18 point font size. Information for the public will be drawn up with the help of disabled people.

2.3 Involvement and consultation

DH has involved disabled people in the development of this scheme (see Appendix 1). We will consult various stakeholders on this scheme and on proposed policies. DH follows the Government's Code of Practice on Consultation, issued by the Cabinet Office, and has issued its own consultation guidelines. The DH Annual Report gives our performance on consultation. Information on consultation exercises can be found on www.dh.gov.uk/news, www.dh.gov.uk/consultation and www.ukonline.gov.uk.

When consulting, DH will ensure that, in terms of disability, it consults both disability organisations and disabled people themselves. We will use different consultative methods for different groups of disabled people. Where possible, we will ask disabled people to undertake consultation on our behalf. We will always give feedback to consultees on the outcome of any consultation. We know, however, that it will take us some time to move from simple consultation to full involvement. DH has well-established mechanisms for involving staff.

2.4 Harassment and bullying

- DH has a policy (Fairness and Respect at Work) on harassment and bullying of departmental staff.
- NHS Employers is responsible for guidance with regard to bullying of NHS staff and also of patients by staff or by other patients.

The effectiveness of these policies will be monitored on a regular basis and they will be reviewed when necessary. We will make sure that there are different routes to use for any complaint and that there is a named person who can be contacted. We will particularly look at ensuring that systems allow for confidentiality and that assurances can be given that victimisation will not occur. We will also ensure that advocates are available for people with learning disabilities.

2.5 Monitoring for equality

Monitoring systems for review of EqIAs and review of policies are being set up (see the action plan). Monitoring users by equality strands is addressed below and in the action plan.

- **Race and religion:** Patients admitted to hospital are monitored by ethnicity. General Practices are required to collect ethnicity data for new patients and this is looked at during formal visits by the PCTs. DH has produced guidance, *A Practical Guide to Ethnic Monitoring in the NHS and Social Care* (2005), on monitoring service users by ethnicity. This booklet is aimed at front-line staff, managers, system designers, boards and committees. The guide also includes advice on monitoring by religion, language and diet. The guidance covers why monitoring is important, the need for this work to be led from the top, which categories to monitor (ethnic codes), the process of monitoring (how to collect the information), and how to analyse and use information collected. It also stresses the need for training staff and informing the public on the importance of ethnic monitoring. In addition, DH is currently looking at how data collection may be improved. We will be looking to ensure that birth and death registration records ethnicity. This will involve engaging with NHS organisations and HM Coroners.

- **Disability:** In October 2006, DH produced guidance for the NHS on measuring impact in terms of disability, *Creating a Disability Equality Scheme: A Practical Guide for the NHS*. This covers involving disabled people, mapping services, assessing policies and action planning. During the workshop involving disabled people in the production of this scheme, we tested which categories people could identify with. Those present were happy with all recommended categories except 'cognitive impairment' (which covers the autistic spectrum disorder). This they felt should be rephrased to be more easily identified by disabled people as representing the category to which they belong. The other categories included 'physical impairment', 'sensory impairment', 'mental health conditions', 'learning difficulty', 'long-standing illness' and 'other' (these are from *Evidence Gathering*, a Disability Rights Commission guide). Those at the workshop stressed the importance of self-definition and the need to have sub-categories and space for those who have multiple disabilities. Information on disability should be collected as part of the single patient record. DH will take these views into account when drafting guidance on monitoring for disability.

- **Gender:** Monitoring by gender is already widespread. In preparation for the introduction of the Gender Duty in April 2007, DH will be looking at how NHS organisations can utilise this data to consider the need to design and deliver gender-sensitive services.

- **Age:** Age information is already collected and monitored.

- **Sexual orientation:** DH recognises the importance of monitoring by sexual orientation. For example, the national census of patients in mental health wards carried out in March 2006 ('Count me in') included monitoring by sexual orientation. In addition, DH commissioned research from Stonewall, 'Monitoring sexual orientation in the health sector', which gives clear guidance on monitoring of staff but advises that further research is needed to establish how best to support monitoring of patients. DH is also participating in a Cabinet Office pilot to consider the best way to introduce monitoring on sexual orientation in employment practice.

2.6 Publication

EqIAs will be published on the DH website. There will also be an annual review of this scheme in the departmental report. This will be accessible in different formats when requested.

2.7 Training

DH has in the past run, as part of diversity training, sessions raising awareness of the Race General Duty. DH plans to run more specific sessions covering the other two duties (see the action plan). We are looking at our training activity strategically, ensuring that the overall strategy is compliant, but also that through monitoring and evaluation of training activity we continually monitor whether the actual training is being delivered consistently across the organisation, and that we amend our strategy and approach in response to this. We are arranging for:

- all senior civil servants to be trained in EqIAs;
- all staff to be trained on the general and specific duty. We will achieve this through prioritising training to communications staff and those in policy making, with training extended across the whole organisation. We are keen to avoid a 'one size fits all' approach and try to ensure that training is made relevant and specific and tailored to role as much as possible across the organisation.

2.8 Employment

- **Recruitment, selection and promotion:** DH monitors staff by ethnicity, gender and disability; this covers recruitment, selection and promotion, training, performance management and pay, discipline and grievances, working patterns and exits (including redundancy and dismissals). Targets are set and measures taken to improve representation at all levels.
- **10-Point Plan:** This is an initiative led by the Cabinet Office to improve the representation of women, black and minority ethnic (BME) staff, and disabled staff in the Senior Civil Service with targets set for 2008. DH's plan focused primarily on

interventions designed to bring in talent in under-represented groups, develop existing staff, and deliver culture change. Our targets include the agency populations and these are reflected in the attached figures.

Senior Civil Service staff in DH and agencies

	Cabinet Office target	DH target	DH position now (incl agencies)
Top women (SCS PB 2 + 3)	30%	35%	32%
Women	37%	43%	42%
BME	4%	10%	6.2%
Disabled	3.2%	6%	3.6%

Equal pay review

DH will be conducting an equal pay audit looking at ethnicity, gender and disability. An action plan will be drawn up to address any disparity in pay (see the action plan).

2.9 Procurement and partnerships

Information on DH's obligations under the Race Relations Amendment Act 2000, the Disability Discrimination Act 2005 and the Sex Discrimination Act are included in the standard terms and conditions for contracting services. Government guidance on equality issues in procurement is followed. Clauses in contracts specify that contractors must comply with legislation, monitoring equality within contracts and training those involved in procurement.

Race equality training is being delivered for NHS procurement staff. A comprehensive review of all purchasing guides is being undertaken and will be completed by March 2007. Monitoring of compliance with guidance has been introduced as part of the audit process.

DH has sponsored the launch of a website produced by one of the former London Strategic Authorities called 'Mosaic' (www.mosaic.nhs.uk), which aims to develop, through pilot sites, good practice for procurement based on Commission for Racial Equality (CRE) guidelines and to promote and disseminate learning from the pilots to the rest of the procurement professionals. The project focuses on three main areas: working with NHS organisations and staff, working with NHS prime or first-tier suppliers, and promoting the use of small- and medium-sized enterprises and BME suppliers in particular. The Department of Health is one of the pilots. Future work will look to provide good practice guidance on embedding equality (across all of the strands) into procurement processes and practices.

DH works in partnership with many organisations, mostly the NHS, strategic health authorities, health trusts and PCTs. DH also works closely with other government departments, local authorities and the voluntary sector. In all its dealings with its partners, DH will ensure that its obligations under the three general duties are observed.

2.10 Complaints

- Complaints in relation to employment by DH should be directed to the line manager of the person complained about. Complaints are dealt with under the Fairness and Respect at Work complaints procedure which includes complaints about discrimination, harassment, bullying and victimisation.
- Complaints in relation to other departmental functions, such as policy matters, should be directed to Head of Knowledge Management, Complaints and Enquiries, Department of Health, Richmond House, 79 Whitehall, London SW1A 2NS.

3. Action plan 2007–10

A detailed action plan is at Appendix 5. Individual directorates will be drawing up their own detailed action plans which will inform the revised Scheme in spring 2007. This section highlights a few of the key actions that the Department of Health (DH) will be taking in the next three years.

3.1 Public Service Agreement (PSA) targets (Appendix 4)

The PSA targets represent the key areas of work for DH over three years. They are agreed between DH and the Treasury. DH is accountable to Parliament, through the Secretary of State, for achieving these targets. In measuring success towards achieving the targets, DH will look at any disproportionality in terms of ethnicity, disability and gender (where information is available), and take remedial action if necessary. Some examples of where this is already happening include smoking, obesity, cancer, diabetes and health inequalities.

3.2 General formal investigation by the Disability Rights Commission

In early 2007, we will publish our response to the Disability Rights Commission's general formal investigation into health inequalities experienced by people with learning disabilities and mental health problems.

3.3 Equality impact assessments

All policies, projects and programmes will have their equality impact assessment (EqIA) status monitored and outcomes checked and recorded. This will be done through monthly reports available on the 1st of every month. EqIA training for Senior Civil Servants will be rolled out from April 2007.

We are currently undertaking EqIAs in the following areas:

- Commissioning framework.
- 'Choice' strategy.
- Patient and Public Involvement (PPI) policy in relation to Local Involvement Networks (LINKS) and complaints.

Future EqIAs include the following:

- *Our health, our care, our say* White Paper: all policy leads will undertake EqIAs on their policies where relevant (2007).
- PSA 7 (patient experience): EqIAs of high-risk projects and programmes (2007 and 2008).
- DH website redesign (following introduction of new content management system) to improve accessibility (2007).
- Non Local Development Plans-based health commission indicators (2007).
- Reward strategy for DH staff (2007).
- NHS pension service and related schemes (2008).
- If there is a revised National Service Framework, each plan will be subject to an EqIA (this would include the second cancer plan) (2008).

3.4 Information

- All published guidance will comply with a DH equality standard that will be produced in 2007.
- Information for the ‘Choice’ strategy will be reviewed with minority ethnic groups in 2007; in 2008, suppliers will be required to provide accessible formats for information.

3.5 Consultation

- Involving and consulting stakeholders (internal and external) on the DH Single Equality Scheme will take place between January and March 2007.
- The process of continuous engagement (especially with disadvantaged groups) will be improved during 2008.
- All policies will take account of input from relevant stakeholders, including end users.
- All the points raised by disabled people in the drafting of this single equality scheme will be considered by policy leads.

3.6 Monitoring

- The information needed for monitoring the implementation of programmes and policies such as ‘Our health, our care, our say’ will be built up in 2007.
- Guidance on equality monitoring for use by DH staff (to include ethnicity, gender and transgender, and disability) will be produced by February 2007.

- As mentioned above, monitoring will be used in assessing PSA targets.
- NHS trusts already collect ethnicity information for new admissions, and mental health trusts will be expected to collect ethnicity data for 100 per cent of admissions.
- As part of the Quality and Outcomes Framework visits to practices, the lessons learned from the collection of ethnicity data will be used to look at collecting data on disability.
- The 'Count me in' survey of mental health patients will include information about gender, disability, age, religion and sexual orientation.
- Monitoring of DH staff covering all statutory data is reported quarterly to meetings of Human Resources programme boards from October 2006.

3.7 Employment

Forthcoming action on employment includes the following (Human Resources produce a diversity action plan that contains a full list of actions):

- Further positive action and a talent strategy will be developed to ensure that DH attracts and retains black and minority ethnic staff (March 2007). This includes the need to identify people from under-represented groups at feeder grade level with clear potential for progression to the Senior Civil Service (SCS) and the need to develop people in this talent pool, including providing suitable mentors.
- DH will target people in feeder grades for development and managed moves to maximise their chances of competing for SCS posts. Final or permanent appointment would always be on merit, and following competition.
- DH will take steps to create diverse longlists and shortlists (mainly for SCS pay band 2 and 3 posts).
- Equality will be incorporated in senior managers' personal performance objectives from April 2007.

See the action plan for more details.

4. Conclusion

The Department of Health's (DH) *Single Equality Scheme* is a living document; it will be regularly revised as new legislation and policies are developed by DH, and if DH takes on new functions. The Scheme will also change as we receive more information from our partners and our stakeholders. In particular, it will change as we receive information and comments from our own staff and members of the public. We have outlined key actions in the body of the Scheme and more detailed actions in the action plan. The different directorates are developing their own action plans that will contain yet more detail.

DH is moving forward on equality issues. We recognise that we still have a long way to go. Our aim is to achieve best practice and to develop and implement health policies and programmes that truly match the needs of the different communities we serve.

Appendix 1: Report on involvement of disabled people

Department of Health Single Equality Scheme

Report on the Workshop with Disabled People on 25 October 2006

1. Introduction

The Department of Health (DH) ran a workshop for disabled people and organisations supporting disabled people to help develop the Department of Health's Single Equality Scheme. Twenty people attended the day-long workshop.

People came from the following organisations:

Guide Dogs for the Blind
The Stroke Association
Foundation for People with Learning Difficulties
Equalities National Council
University of Bristol School of Medicine
National Autistic Society
RNID
Deafblind UK
South Birmingham PCT
Linkage Community Trust
Eastern Mentor
United Response
Vitalise
National Association of Deafened People
National Federation of the Blind of the UK
MIND
EnABLE (DH disabled staff group)

An external consultant facilitated the workshop and staff from DH helped lead discussion groups and take notes. Participants had a variety of disabilities including visual and hearing impairments, mobility impairment and learning difficulties. There were an equal number of men and women, and participants belonged to different ethnic groups.

Two palentypists and one signer helped throughout the day.

2. Workshop format

The day started with a presentation on what a Single Equality Scheme was and why DH was running the workshop. Participants were divided into groups and seated at round tables. Facilitators at each table made sure that everyone was able to contribute to the discussion. The day was built around a series of sessions looking at different issues. Each session lasted 45 minutes, starting with a two-minute presentation followed by round table discussions. Sessions ended with a 10-minute plenary. We chose as topics for discussion issues we needed to address in the Single Equality Scheme. Topics chosen were: access to information, involvement and consultation, bullying and harassment, and monitoring. We left one discussion slot at the end of the day for people to raise any other issues concerning access to services.

All information gathered was then used in drafting the Scheme. The following is a summary of points raised by participants on the different topics.

3. Access to information

Participants were asked to comment on which means of information giving they preferred and to give suggestions for improvement.

- There should be a wide variety of formats available.
- Information should be in plain English and ‘friendly looking’, and should include pictures.
- Most people cannot access non-visual information.
- For many disabled people, and particularly black and minority ethnic (BME) disabled people, it is better to impart information face to face.
- The most effective information people had received was always face to face.
- Practice nurses could be used to pass on information face to face.
- Efforts must be made to get information to homeless people.
- Apart from face to face, information is best through posters and advertisements on TV or radio.
- If different formats are available on request, it needs to be made clear where to get them and not just give a telephone number. There should be a choice for contact so that those, for example, with hearing or speech impairments can access the information they need. Contact numbers for requests of different formats should not be written in small print.

- Contact details on leaflets for more information should also be available through different routes (telephone, email, text, postal, fax, etc).
- If a website address is given for more information, it should be specific and not just a general website leaving the users to hunt down the information needed.
- Font size 18pt should be standard. (An example given was that in one primary care trust [PCT] area GPs increased the uptake of flu jabs from 30 per cent to 65 per cent just by using font size 18pt on the information that was distributed.)
- Use colour contrasts.
- Information needs to be multi-layered, ie directed at disabled people as well as carers.
- Information through DVD is very useful. It should be sub-titled or signed (both should be on offer, but not together on the same DVD).
- Information needs to be timely, ie given while still in hospital not after having left.
- Information on complaints or Patient Advice and Liaison Services (PALS) should give more than just a telephone number; it must be accessible to British Sign Language users (eg a postcard).
- Health and social care staff need training in how to communicate and where to get advocates to help with those who have learning difficulties (important for the choice agenda).
- The Department of Health should set standards for PCTs and health trusts on how to communicate (or guidelines).
- Disabled people should always be involved in drawing up information for the public.

4. Involvement and consultation

People were asked how consultation or involvement should occur in policy or service development or in impact assessments.

- Ensure involvement is genuine and not tokenistic.
- Be creative about involvement, do more than involve the usual suspects.
- Involvement should happen at two levels: organisations and individual disabled people themselves.
- Don’t just consult voluntary organisations, consult disabled people directly.
- Go to local groups not just national organisations.
- Use GP lists to contact disabled people.

- Don’t make involvement complicated or intimidating.
- Use the expertise of disabled people who may be seasoned users of NHS social care. Listen to how they have overcome barriers.
- Consultation must be face to face for people with learning disabilities (PLD).
- You need to hear the overall voice, not just the strongest voice.
- Use different methods for different disabilities. (Don’t use a telephone survey with deaf people!)
- Use existing mechanisms to consult: eg Royal National Institute of the Blind (RNIB) magazine.
- Don’t be tokenistic: acknowledge that no one is representative of a whole group of people.
- There needs to be a mechanism for self feedback.
- Get front-line staff involved, get them talking to people to collect views.
- Get disabled people to do the consultation on behalf of health and social care providers and pay them!
- Set up forums of service users.
- Give feedback to consultees about the outcome of the consultation and decisions taken. Consultation fatigue results from lack of communication after consultation.
- Develop the capacity for participants to be fully involved.
- Don’t just consult a self-selected group.

5. Bullying and harassment

This session covered bullying and harassment from staff to users, from users to staff and from user to user.

- Ensure there is guidance for the residential sector.
- Harassment and bullying occur largely because there is a lack of understanding around disability – raise awareness on disability through campaigns or training.
- Help staff to identify bullying and harassment.
- More training is needed for staff in raising awareness about bullying and harassment and how to deal with it.
- Ensure there is a confidential reporting system.

- Extend PALS to include reporting bullying and harassment.
- Put systems in place that reassure people there will be no victimisation following a complaint.
- Any complaints procedure should be simple and quality assured.
- Always include a named person to contact.
- Have lots of different routes to use for a complaint.
- Encourage complaints: the climate must be receptive to change.
- Address the culture of the organisation.
- Provide advocacy for PLD.
- Harassment at work often happens because there is a lack of knowledge of funding available (eg Access to Work).
- DH should identify the extent of the problem (bullying by staff to patients).

6. Monitoring categories

Participants were shown the list of categories recommended by the Disability Rights Commission (DRC) in its publication *The Disability Equality Duty: Guidance on Gathering and Analysing Evidence to Inform Action.* Participants were asked for their views on the use of suggested categories to collect information for monitoring purposes.

- Always use self-definition where possible.
- Make it clear what the information will be used for.
- Avoid jargon – people will not identify with 'cognitive impairment'.
- Categories should not be too rigid – need sub-categories.
- How do you capture people who have 'cerebral palsy', which falls into several categories?
- How do you ensure correct categorisation of people with multiple impairments?
- How do you capture those who are disabled but do not consider themselves disabled?
- Link all information collected to gender and ethnicity.
- Monitoring information should be collected as part of a single patient record and should follow the patient through health service and social care services.
- Information for assessing an individual's needs is different from information collected for statistical purposes. The first is confidential to that patient and those caring for him or her, the second is anonymous and not linked to any individual. The first is to find out needs (eg communication needs), the second is to prevent discrimination.

- It may be better to categorise people by need rather than by impairment.
- In planning services, information on needs is more useful than on the standard impairment categories.

7. Access to services

People were asked to raise any issue of access to services or any other issue they felt had not been covered in the other sessions.

- There should be a single point of contact for those with multiple needs, eg muscular dystrophy and PLD.
- Many premises are still not accessible.
- Independent living is an important part of the picture.
- There is a need to look at the cultural views that exist in society of some disabilities.
- There should be more shared learning across NHS and social care.
- The NHS is obsessed with handling things over the phone! Other means of contact should be offered.
- Action on sexual health should consider the needs of adults with autism or PLD.
- Guidelines should be drawn up on sexual health for PLD and also cover relationships and contraception. An example was given of Lincolnshire NHS Trust that produced a video on sexual health made by PLD.
- Need better access to psychiatric services for PLD.
- Cervical smears, breast screenings: residents in care homes are not being invited to attend.
- Screening the machinery is not appropriate for many disabilities.
- Transport should be available for people to attend screening.
- Waiting rooms are often not adapted for those who are blind; staff could tell them when it is their turn. They don't as there is a lack of awareness around the needs of blind people.
- Public health posters should include images of disabled people.

8. Conclusion

At the end of the day, people were asked if they would like to participate in similar workshops, particularly helping DH in undertaking equality impact assessments (EqIAs). All participants were interested in continuing to help improve services in this way. DH thanked everyone who attended and made it clear that the developmental version of the Single Equality Scheme, together with the report on the workshop, would be sent to all participants.

Appendix 2: Department of Health equality impact assessment tool

Equality impact assessment

Why this is important

All individuals and population groups should have equal opportunity to benefit from DH policy. But inequalities in health between different ethnic groups and between men and women are well documented and long-standing. We cannot simply assume that health policy will be equally beneficial for everyone. A professional approach to policy making means testing our assumptions. By assessing potential effects of a policy on particular populations in a rigorous way, we can increase the probability that a policy will promote equity of outcomes.

Equality impact assessment (EqIA) is also a legal requirement. Public bodies have for many years been required not to discriminate in the delivery of their services or in employment on grounds of gender and race. Since 2002, public authorities have been required to assess and monitor the impact of all relevant policies on race equality. A similar duty comes into force in December 2006 to assess the impact of policies on disabled people under the Disability Discrimination Act 2005. The Equality Act 2006 will impose a duty to promote equality between women and men from April 2007. Another part of the Equality Act will prohibit discrimination in service delivery on the basis of religion or belief and sexual orientation. We must also pay due regard to underpinning human rights issues – see **Human Rights**.

If policies are assessed for their impact on different sections of the population from the outset, we are better placed to meet our legal obligations. More importantly, we are more likely to produce better policy that will benefit everyone in the population.

How to conduct equality impact assessment

EqIA is a two-step process.

1. Screening

To find out if an EqIA may be necessary, you first need 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 potential to have a differential or negative effect on equality. Screening for relevance to equality needs to happen at the very beginning of the development phase of a policy. This is a process that must be undertaken honestly, by finding out what you don't know, you will be able to determine what you need to find out before going any further. The process and findings of screening need to be recorded. See **Equality Screening**.

2. Impact assessment

If an EqIA is required, see **Equality Impact Assessment** for a step-by-step guide.

Further help and advice is available from the Equality and Human Rights Group. Contact Robin Feline, 020 7972 5004 Skipton House.

Equality screening

Policy Aim

Before undertaking screening of a policy, take some time to ensure everyone involved in the process understands what the policy is for. For any substantial policy, it is likely that you will need to look at relevance for each area or section of the policy, as some aspects may be more relevant or carry more risk than others.

Set out:

- the title of the policy programme
- what you are trying to achieve in this policy or part of the policy
- which population groups the policy (or section) is intended to benefit and how
- related policy areas that may be affected by changes in this policy (or section).

Screening

Question 1

For each of the six equality categories, ask the questions in the table below.

	Age	Disability	Race	Religion and belief	Gender	Sexual orientation
1.a) Do different groups have different needs, experiences, issues and priorities in relation to the proposed policy?						
1.b) Is there potential for, or evidence that, the proposed policy will promote equality of opportunity for all and promote good relations between different groups?						
1.c) Is there potential for, or evidence that, the proposed policy will affect different population groups differently (including possibly discriminating against certain groups)?						
1.d) 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?						
1.e) Is there doubt about answers to any of the above questions (eg there is not enough information to draw a conclusion)?						

If the answer to any of the above is 'yes', you will need to carry out an equality assessment in the relevant equality area(s).

Question 2 Why have you come to these conclusions?

Write short notes to explain why you have drawn your conclusions, including any evidence (of whatever type) that you have to support your assessment.

Based on the information set out above, I have decided that an equality impact assessment is/is not necessary.

Signed:

Business area: **Date:**

Equality impact assessment – *where screening of policy undertaken and EqIA required*

Title:

Aim and purpose of this section of the policy

Having decided that an EqIA is needed, the next step is to determine the scope of the impact assessment. Answering the questions below will help decide what time, resource and expertise you will need and who should be involved. For instance, a proposed policy where the risk or potential for negative effects on equality is small may require only a documentation review or a workshop with the main interested parties to clarify what the risk is, identify mitigating action and decide what monitoring to do in the future. A policy area where the potential is assessed as high may need an extended period, during which research is commissioned and a large number of people are engaged in discussion about potential risks and how they may be mitigated.

Involve the main interested parties from the outset, including external stakeholders, in scoping, planning and delivering the EqIA. It would be prudent to involve DH Gateway at this stage.

Scoping questions

1. What evidence have you used to support the conclusions drawn in screening questions 1a – 1e?

2. What is the strength of this evidence – for instance
   a) well established and validated?
   b) strong evidence, but a few gaps?
   c) some evidence, but considerable gaps?
   d) anecdotal?

3. If the evidence is not sufficient, what other information is needed?

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

5. Does the policy area: **Yes/No**
   - affect a large number of people (eg it covers service provision such as primary care)
   - have risks or potential attached to its implementation and delivery in relation to equality because, for instance, it relates to
     - strategies or services specific to a particular group, eg older people, pregnant women or mental health services for deaf people
     - a disease or service area where a disproportionate number of some population groups are affected, such as coronary heart disease, HIV or ophthalmic services?

6. What is the probability of adverse or beneficial effects?
   - Risk of adverse effects on equality (indicate one)

Highly likely to have adverse effect on equality *High risk*	May possibly have adverse effect *Moderate risk*	Probably will not have adverse effect *Low risk*

   - Potential for benefit (indicate one)

Highly likely to promote equality of opportunity and good relations *High potential* *(Low risk)*	May have the potential to promote equality and good relations *Moderate potential* *(Moderate risk)*	Probably will not promote equality or good relations *Low potential* *(High risk)*

7. If the risks came to pass, how substantial would they be (in terms of the number of people affected and the severity of the problem)?

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

Next steps

1. The availability and strength of evidence

- Based on answers from the scoping work, clarify for each area of the policy and population group that may be affected:
  - the quality and extent of information available
  - what are the gaps in knowledge
  - what can be done to fill the gaps, such as:
    - commissioning new research
    - literature review
    - rapid appraisal
    - convening of expert panel
    - requesting information collected by other organisations
    - anything else.
- Commission or undertake further intelligence gathering as needed.
- Make the information available to interested parties. Make sure you feed back the findings to those who have contributed.

2. Follow up and engage other interested parties

- Ensure potential stakeholders are aware of the proposals and the EqIA process, and are given the opportunity to participate.

3. Forming a judgement on the information – the impact assessment

- The heart of the impact assessment is what conclusions can be drawn from the evidence. For each area of policy and for each population group that may be at risk, it is useful to consider:

- *What is the situation now?*
  The extent of existing disadvantage or discrimination experienced by a population group in the area that this policy is intended to influence (eg disproportionate burden of illness or documented poorer access to a service).

  Information gathered on this topic should help answer the question: do different groups have different needs, experiences, issues and priorities in relation to the proposed policy?

- *The risks and potential in the proposed policy*
  This section needs to cover for each population group the:

  – potential for unlawful discrimination

  – potential for adverse impact on equality of opportunity and good community relations

  – risk of not narrowing the gap in existing inequality

  – potential for narrowing the gap in existing inequality

  – potential for promoting equality of opportunity and good community relations.

- *What outcomes do we want to see?*
  What would a successful outcome look like (eg access to a service on the basis of illness prevalence in the population, a risk of illness no greater than the population average, a reduction in assumptions and cultural stereotyping by staff)?

- *How can we bring those outcomes about?*
  These can be looked at under headings such as:

  – action needed for potentially unlawful areas

  – measures needed to target and redress existing disadvantage (to narrow the gap)

  – measures needed or possible alternatives to ensure a group or groups are not disadvantaged by the policy as well as:

- measures that will build on potential for promoting equality and good relations between different groups
- are measures suggested to promote equality of opportunity or to redress disadvantages lawful?

Information and ideas gathered and discussed under this heading should help determine mitigating action that is needed, how effective this action might be and whether additional strategies or policies may be needed to support mitigation.

- *What will we do?*
  It is useful to summarise who will need to take forward actions, and an idea of the practicalities, as this will be helpful in the consultation and final report and encourage people to be realistic in their discussions and proposals.

  This should include what NHS organisations need to do when they implement the policy, particularly in relation to local impact assessment and monitoring for unforeseen adverse consequences.

- *Measuring progress*
  - What monitoring will be needed in the future to check that the desired outcomes are achieved for each population group?
  - How could this happen? Who will measure what and when?
  - Are you proposing new data collections? If so, you should contact Gateway/Review of Central Returns (ROCR) for advice at the earliest opportunity.

  This should include suggestions as to what NHS organisations will need to monitor, performance monitoring and other reporting.

- *Reporting on findings and deliberations*
  This is what needs to be done for any consultation document.

4. Consultation on the findings of the EqIA

- The purpose, method, findings, conclusions and preliminary recommendations of the EqIA should be disseminated for comment. Make sure you have thought through how to facilitate engagement from potential stakeholders.
- If there has been effort and imagination given to ensuring interested parties have been engaged throughout, then a consultation is the opportunity to feed back to these people and to check for consensus. It is a further opportunity for interested parties to get involved and for the wider public to find out and comment on findings.

- Any additional findings or comments from the consultation should ideally be considered by the original project group or advisory panel and form part of the final report with a response.

5. Decision

- Decisions on changes and the final policy should go into the final EqIA.

6. Publication of EqIA

- An EqIA could be published as part of the policy white paper or as an appendix to a policy statement or separately. Whatever approach is chosen, an EqIA should be identifiable as an EqIA.

Human rights

The Human Rights Act, which came into force in October 2000, incorporates into domestic law the European Convention on Human Rights to which the UK has been committed since 1951. Section 6 of the Human Rights Act makes it unlawful for a public authority to act in a way that is incompatible with a Convention right. The underlying intention of the Act is to create a Human Rights culture in public services.

If you think that the policy may have Human Rights implications, you may wish to consider the following questions:

- will it affect a person's right to life?
- will someone be deprived of their liberty or have their security threatened?
- could this result in a person being treated in a degrading or inhuman manner?
- is there a possibility that a person will be prevented from exercising their beliefs?
- will anyone's private and family life be interfered with?

If the answer is 'yes' to any of these questions, can the policy be amended to avoid impacting upon Human Rights? If not, seek legal advice before proceeding.

Appendix 3: 10-Point Action Plan

Delivering a Diverse Civil Service: A 10-Point Plan

What is it?

The 10-Point Plan sets out 10 key points that the head of the Civil Service and the Civil Service Management Board have committed to. It will help us achieve a more diverse Civil Service workforce, especially at senior levels.

Why do we need it?

The Civil Service must be relevant to the customers it serves. As part of a wider commitment to build the capacity of the Civil Service to deliver excellence in public services, through improving leadership, skills and diversity, the Government set new diversity targets to achieve by 2008:

- 37 per cent of the Senior Civil Service (SCS) to be women
- 30 per cent of top management posts to be filled by women
- 4 per cent of SCS to be from minority ethnic backgrounds
- 3.2 per cent of the SCS to be disabled people.

The 10 key areas for change

1. Targets

Targets for the SCS as a whole are now underpinned by departmental targets.

Departments have their own stretching targets for their SCS and feeder grade populations. They will have robust plans, signed off by their permanent secretaries or chief executive equivalents, to meet these targets. Diversity delivery plans will be fully integrated into business plans and current and emerging equality schemes.

2. Measurement and evaluation

We need to know whether our action is succeeding. Departmental and corporate monitoring will provide checkpoints on progress, and opportunities to take different action where necessary.

The Cabinet Office will continue to publish SCS data every six months and will continue work to improve data quality, collection and coverage. Departments will also continue to work to improve data coverage and quality.

3. Delivering on diversity through the Diversity Champions' Network (DCN)

We need to ensure that change happens across the whole Civil Service. The DCN is a network of very senior diversity champions across departments and agencies.

It is chaired by the Civil Service Diversity Champion and supported by the Chief Diversity Adviser. DCN members are responsible for driving delivery of the 10-Point Plan in their departments and agencies. They are individually responsible to the permanent secretaries or chief executives for the delivery of their organisation's diversity targets. The DCN will monitor progress on the 10-Point Plan and report to the Civil Service Management Board annually. The DCN meets quarterly and works in self-running sub-groups on key issues in between whole network meetings.

4. Leadership and accountability

Visible leadership commitment to diversity is a key enabler of success.

Permanent secretaries and chief executives are accountable for diversity in their departments and agencies, including departmental diversity targets for their SCS and feeder grade populations. The head of the Home Civil Service will hold permanent secretaries to account for their diversity targets in the performance discussions he holds with each one. Diversity champions will provide six-monthly reports to the network on progress on departmental action plans.

5. Recruitment

We need to make sure that the Civil Service is an employer of choice for talented people from under-represented groups.

Departments will ensure that positive action is incorporated in all recruitment policies and practices, including outreach and marketing, targets for contracts with search consultants, or recruitment advertising agencies on attracting under-represented groups. The Fast Stream Development Programme is the main graduate entry route for SCS careers. We will continue to improve the diversity profile of its intake to build a more diverse talent pool for the future.

6. Development

Identification and accelerated development of talented people from under-represented groups in the grades just below the SCS is key to success.

Corporate diversity development schemes are being redeveloped and relaunched following a review. These will be complemented by departmental schemes. Departments will also have targeted appropriate development for staff below the feeder grades.

7. Behaviour and culture change

The Civil Service must demonstrate that it has a policy of zero tolerance of discrimination on any grounds and of bullying behaviour.

We will promote and embed equality and diversity in every aspect of people management systems, including meaningful and measurable diversity objectives linked to reward systems. We will increase understanding among managers of their role in challenging discrimination and unacceptable behaviour. And we will continue to work with our partners in trade unions and staff networks to influence organisational culture change.

8. Diversity impact of the efficiency and relocation reviews

Maintaining a diverse workforce and talent pool for the future is important to achieve our longer term aim of a Civil Service that represents the population at all levels.

We want to ensure that the Civil Service remains representative of the population in terms of gender and ethnicity, and to improve representation of disabled people. We will keep a watch on the overall diversity impact of efficiency and relocation plans, and departments are carrying out impact assessments to ensure that no particular group of staff is unfairly discriminated against.

9. Mainstreaming diversity

Equality and diversity must be on the agenda at all levels, in every part of our organisation if it is to succeed. It cannot be a bolt-on to other policies and initiatives.

This means it must be mainstreamed or embedded in policy development, service delivery and business and workforce planning. Departments will use existing statutory duties on race – that will be mirrored for disability and gender – to provide a starting point for introducing a discipline of integration of equality and diversity matters across the range of departmental policy and operational functions.

10. Communication

There will be an effective communication strategy at corporate and departmental level, for clear internal and external messages, to ensure success of the plan.

Communication plans will form part of departmental diversity plans and will articulate the business, moral and ethical case for diversity.

Appendix 4: PSA targets

PSA	Target
Reduce mortality from heart disease and cancer	Reduce mortality rates from heart disease, stroke and related diseases by at least 40 per cent in people aged under 75 by 2010.
	Reduce mortality rates from heart disease, stroke and related diseases with a 40 per cent reduction in the inequalities gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole.
	Reduce mortality rates from cancer by at least 20 per cent in people aged under 75 by 2010.
	Reduce mortality rates from cancer with a reduction in the inequalities gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole.
	Reduce mortality rates from suicide and undetermined injury by at least 20 per cent.
Reduce health inequalities	Reduce health inequalities by 10 per cent by 2010, as measured by infant mortality.
	Reduce health inequalities by 10 per cent by 2010, as measured by life expectancy at birth.
Tackle the underlying determinants of health and health inequalities	By reducing adult smoking rates to 21 per cent or less by 2010, with a reduction in prevalence among routine and manual groups to 26 per cent or less.
	Halting the year-on-year rise in obesity among children aged under 11 by 2010, in the context of a broader strategy to tackle obesity in the population as a whole.
	Reducing the under-18 conception rate by 50 per cent by 2010, as part of a broader strategy to improve sexual health.

Long-term conditions	To improve health outcomes for people with long-term conditions by offering a personalised care plan for the most at risk vulnerable people, and to reduce the emergency bed days by 5 per cent by 2008.
18 weeks (some sub-elements included above)	To ensure by 2008 no one waits more than 18 weeks from GP referral to hospital treatment.
Drug treatment	Increase the participation of problem drug users in drug treatment programmes by 100 per cent by 2008. Increase year on year the proportion of users successfully sustaining or completing treatment programmes.
Patient experience	Secure sustained national improvements in patient experience as measured by independently validated national surveys. Ensure that individuals are fully involved in decisions about their healthcare, including choice of provider, as measured by independently validated surveys.
Older people	Improve the quality of life and independence of vulnerable older people by supporting them to live in their own homes where possible. Increase the proportion of older people being supported to live in their own home by 1 per cent annually in 2007/08. Increase by March 2008 the proportion of those supported intensively to live at home to 34 per cent of the total being supported at home or in residential care.

Appendix 5: Single Equality Scheme Action Plan

Department of Health Single Equality Scheme Action Plan 2006–09

Note: some actions cover more than one goal but for convenience have been put under just one of the seven.

Goal 1. To lead sustained improvements in public health and well-being, with specific attention to the needs of disadvantaged and vulnerable people

Outcome	Action	Responsibility	Timescale	Strands
In implementing public service agreement (PSA) targets 1–3 ensure that there is no discrimination in the development of the Memorandum of Understanding (MOU) and business plan between government officers, strategic health authorities and the Department of Health (DH)	Development of MOU to improve health and protect health of the population in the regions. Sign off the MOU and ensure the content of 2007/08 agreement is adjusted. Ensure this is formally reviewed as part of the review for the 2007/08 annual MOU agreement	Regional public health groups (RPHGs)	Year 1	All
Improved outcomes in services for men and women	Produce NHS guidance on the gender duty	Equality and human rights group (EHRG)	Year 1	Gender
Improved outcomes in services for men and women	Develop guidance with the Equal Opportunities Commission to determine how men and women access services and to measure outcomes	EHRG	Year 1	Gender
Improved outcomes in services for men and women	Establish DH gender advisory group	EHRG	Year 1	Gender
Improved outcomes in services for men and women	Commission gender research through men's health forum	EHRG	Year 1	Gender
Improved outcomes in services for men and women	Run regional awareness-raising events on gender	EHRG	Year 1	Gender

Goal 1. To lead sustained improvements in public health and well-being, with specific attention to the needs of disadvantaged and vulnerable people *(continued)*

Outcome	Action	Responsibility	Timescale	Strands
Transgender issues addressed in health and social care provision	Develop an action plan to address discrimination against transgender people	EHRG	Year 1	Gender
Successful sexual health campaign	Pre-host new campaign to ensure it does not disadvantage	HIV and sexual health team	Year 1	All
Better access to sexual health	Consider race and ethnicity data collected in genito-urinary medicine for HIV and other sexually transmitted infections	HIV and sexual health team	Year 1	All
Improved access to dental care	Review and analyse baseline data gathered since April 2006	Dental team	Year 1	Race
Improved access to dental care	Consider what baseline data exists for all other strands and make recommendations on action needed	Dental team	Year 1	Gender, disability, religion, sexual orientation, age
Equality integrated in the Prime Minister's Delivery Unit/HM Treasury self-assessment process	Meet with those responsible to ensure that the self-assessment process takes into account progress on promoting equality in specific areas	NHS performance policy and priorities and planning team	Year 1	All
Improve access to health service for black and minority ethnic (BME) and disability groups	Consider how to ensure that the lessons from the current ethnic monitoring requirement in the quality and outcomes framework (QOF) are extended to disability	QOF team	Year 2	Race, disability
Improved access to GP services	Consider how to ensure that the QOF for GPs tackles health inequalities and health needs	QOF/primary medical care team	Year 2	All
Cancer awareness for BME communities	The project aims to provide accessible information about cancer awareness	The Afiya Trust	Reports year 2	Race

Goal 1. To lead sustained improvements in public health and well-being, with specific attention to the needs of disadvantaged and vulnerable people *(continued)*

Outcome	Action	Responsibility	Timescale	Strands
Cancer awareness for women	The ‘Hear for you, near for you’ project aims to target women in the workplace to dispel the myths and misconceptions about breast cancer	Breast Cancer Care	Reports year 2	Gender
Cancer and diet information for BME communities	The project aims to establish a library of information about cancer diagnosis, treatment, palliative care and follow-up to BME people with cancer, their families, friends and professionals working with them	Cancer Equality	Reports year 1	Race
Cancer information for Asian people	The project aims to provide information materials about cancer translated into Asian languages, including on treatment and living with cancer	Cancer Resource Centre	Reports year 1	Race
Breast cancer awareness in women aged over 50: 90% of women over 50 having mammograms every three years	The project aims to print 100,000 credit card leaflets to encourage early presentation for those who have symptoms of breast cancer, especially women from BME communities, the elderly and women with learning disabilities	Breakthrough Breast Cancer	Reports year 2	Gender, age, disability
Cancer information and patient support group for the Turkish community	The project aims to assist Turkish cancer patients, their families and carers with advice, help and information about cancer so that they can make an informed choice about making decisions	Pro Cancer Research Fund	Reports year 3	Race
To reduce the inequalities gap between the fifth of the areas with the worst health and deprivation indicators and the population as a whole	Support the implementation in regions through work with primary care trusts (PCTs)	Cancer policy team/RPHGs	Years 1 to 3	Race

Goal 1. To lead sustained improvements in public health and well-being, with specific attention to the needs of disadvantaged and vulnerable people *(continued)*

Outcome	Action	Responsibility	Timescale	Strands
Equal access to cancer treatment	Take forward recommendations in *Ethnicity and Cancer* report (see report for detailed actions)	Cancer policy team	Year 1	All
Equal access to cancer treatment for those with prostate cancer	Consider taking forward recommendations of *Tackling prostate cancer in BME groups* report (see report for detailed actions)	Cancer policy team	Years 1 to 3	Race
Equal access to cancer screening services	Breast cancer poster targeted at older women	NHS cancer screening programme	Year 1	Age
Equal access to cancer screening services	Breast screening information (DVD, leaflets) targeted at BME communities. Targeted campaigns for cervical and bowel cancer	NHS cancer screening programme	Years 1 to 3	Race
Increased cancer awareness for women	'Hear for you, near for you' project targeting women in the workplace	Breast Cancer Care	Reports year 1	Gender
Equal access to end-of-life care for all	The development of the DH End-of-Life Care Strategy was announced in June 2006. The aim is to seek agreement to the strategic direction from ministers in November 2006, with a high-level framework due to be published in spring 2007. Action is likely to take five years	Cancer policy team	Years 1 to 3	All
Ensure that all aspects of the Choosing Health agenda are free from discrimination or bias	Obesity, diet, diabetes, smoking cessation, alcohol and substance misuse will be looked at in terms of prevalence, susceptibility and access to healthcare services by various communities. Issues found will be addressed	Choosing Health team and regional Choosing Health leads	Years 1 to 3	All

Goal 1. To lead sustained improvements in public health and well-being, with specific attention to the needs of disadvantaged and vulnerable people *(continued)*

Outcome	Action	Responsibility	Timescale	Strands
Equal access to palliative care for all	The project aims to formulate guidance on service models in meeting the palliative care needs of BME elderly people through interactive workshops with voluntary sector organisations and service providers to raise awareness of palliative services for this group	Policy Research Institute on Ageing and Ethnicity	Reports year 1	Race, age
Equal access to palliative care for all	Ensure that the content of local area agreements reflects local demographics and local needs	RPHGs	Years 1 to 3	All

Goal 2. To enhance the quality and safety of health and social care services, providing faster access and better patient and user choice and control

Outcome	Action	Responsibility	Timescale	Strands
Clinical reference group on commissioning takes account of inequalities issues	Build equalities into the terms of reference to ensure that issues are foreseen before the formal development stage of policy	Priorities and planning	Year 1	All
Information technology enabling patients to participate more fully in their own healthcare	Assess all relevant activities of NHS Connecting for Health in delivering information technology and systems for any adverse impact	Connecting for Health	Year 1	All
Equality embedded at all levels within Connecting for Health	Screen for possible full equality impact assessment (EqIA) at the formative policy and design stages and ensure subsequent monitoring during implementation	Connecting for Health	Year 2	All
No discrimination in development of action	Consult with key stakeholders including BME groups and disability groups on the implementation of the Children's National Service Framework (NSF) – Flying Start programme	Children and families team	Year 1 (April)	Disability, race

Goal 2. To enhance the quality and safety of health and social care services, providing faster access and better patient and user choice and control *(continued)*

Outcome	Action	Responsibility	Timescale	Strands
No discrimination in implementation of action	Children's NSF – Flying Start programme: implication and assessment of costed delivery plan	Children and families team	Year 1 (February)	Disability, race
Fair policy on in vitro fertilisation (IVF) services	Develop clear guidelines on age and IVF services	Scientific development of bioethics	Year 1	Age, gender
Equal access to mental health care	Continue implementation of *Delivering race equality in mental health care* (2005–10) (DRE)	Mental health team	Year 1	Race, religion
Equal access to mental health care	Revise Mental Health Act code of practice in a way that reflects the priorities in the Single Equality Scheme	Mental health team	Year 2	Race, disability, gender
Equal treatment of mental health patients	Develop evidence review and action plan to deal with gender issues in mental health, eg dangers of mixed-sex acute wards	Mental health team	Year 3	Gender
Equal access to mental health care	Develop programme of work on mental health services for older people	Mental health team and social care directorate	Year 1	Age
Equal access to cancer treatment	Take forward recommendations in *Ethnicity and cancer* report	Cancer policy team	Year 1	Race
Better quality of care	Publish quality framework for health and social care	Health and social care standards and quality	Year 1 (February)	All
Aligned health and social care standards fitting with new health reform systems management and regulation	Review impact of *Standards for better health* in light of the proposed changes in systems management and regulation	Health and social care standards and quality	Year 1	All

Goal 2. To enhance the quality and safety of health and social care services, providing faster access and better patient and user choice and control *(continued)*

Outcome	Action	Responsibility	Timescale	Strands
Awareness concerning MRSA equal across all groups of people	Ensure that the communication strategy is revised to communicate with all sections of the population, including targeting specific groups and communicating with them in appropriate ways	MRSA team	Year 2 (January/ February)	All
Awareness concerning MRSA equal across all groups of people	Monitor communication strategy	MRSA team	Year 2 (March)	All
Ensure that there is no inequality in the treatment of healthcare-acquired infections	Look at means of measuring the impact of healthcare-acquired infections on different groups of patients (elderly, BME or disabled patients)			Race, disability, age
Improved children's and young people's diabetes services	Develop and publish commissioning guidance on children's and young people's diabetes services	Diabetes team	Year 1	All
Improved care for people with diabetes	Develop and publish guidance on care planning	Diabetes team	Year 1	All
Equality of access to insulin pump services	Develop and publish commissioning guidance on the provision of insulin pump services	Diabetes team	Year 1	All
Improved care for people with diabetes	Development of the 'Year of care' commissioning process	Diabetes team	Years 2 and 3	All
Improved care for people who have suffered a stroke	Development of a stroke strategy	Vascular programme team	Year 1	Age, disability, gender

Goal 3. To deliver an improved care experience for patients and users, including those with long term conditions

Outcome	Action	Responsibility	Timescale	Strands
Equality mainstreamed throughout policy development	Produce 'how to' guidance for policy makers covering components of the Single Equality Scheme to ensure competence, confidence and consistency of approach	EHRG	Year 1	All
Policies that address diverse needs	Train identified line managers and specialists who need to conduct independent reviews of EqIAs and ensure they have the capability and support necessary to undertake EqIAs	Organisational development	Year 1	All
Policies that address diverse needs	Identify and agree with the policy committee key areas in which to conduct EqIAs	EHRG	Year 1	All
All older people treated with dignity	Build a national awareness campaign – events, stakeholder meetings, guidance	Policy management unit	Year 1	All
Non-discriminatory policy on consent to treatment and examination	Revise DH guide on 'common law' consent and best practice, addressing age, learning disability (capacity) and cultural sensitivities	Scientific development and bioethics	Years 1 and 2	Age, disability, gender, race
Non-discriminatory pension, compensation and Incapacity Benefit (IB) schemes	Equality audit of operation of NHS pension, compensation and IB schemes (new and old)	DH pay and pensions	Year 1 (April)	All
No discrimination in the Information for Choice strategy	Evaluation of first phase of pilots for information prescription is complete	Information for Choice programme team	Year 1 (March)	All
Gaps identified in information for patients	Information review (patient journey and 'mystery shopper' activity) report will highlight gaps in patient information	Information for Choice programme team and DH customer service directorate	Year 1 (January)	All

Goal 3. To deliver an improved care experience for patients and users, including those with long term conditions *(continued)*

Outcome	Action	Responsibility	Timescale	Strands
Equal access to mental health services	Begin new strand of work monitoring and understanding the impact of the new Mental Health Act. This will be integrated into the main BME mental health programme and will inform the implementation of the DRE action plan	Mental health team	Year 1 (February)	Race
Fair implementation of *Our health, our care, our say* White Paper	Ensure metrics and measures for implementation of the White Paper include the information required to allow an assessment of the impact of the shifting care agenda across all groups	White Paper implementation team with statisticians and individual policy leads	Initial development in Year 1; further development and use of available information in Years 2 and 3	All
Equal access to mental health services	Annual 'Count me in' census of mental health and learning disabled inpatients (and sample of community patients). Identifies ethnicity, gender, age, faith, sexual orientation and disability	Mental health team	Years 1–3 (March)	All, but mainly race
Equal treatment in mental health care	More research into factors causing the disproportionate use of sectioning for young black men	Mental health team	Year 2	Race
No stigma to mental health patients	Action to promote a reduction in stigma of mental illness. Review and build on previous initiatives	Mental health team	Year 2	Disability
Fair access to choice of midwife	Children's NSF – Flying Start programme – Maternity: re manifesto commitment to have 'named midwife by 2009'. Consultation and review on choice/access with stakeholders: BME groups, religious groups, etc	Partnerships for children, families and maternity	Year 2	All

Goal 3. To deliver an improved care experience for patients and users, including those with long term conditions *(continued)*

Outcome	Action	Responsibility	Timescale	Strands
Accessible information	Accreditation scheme goes live: will it cover accessible formats? If not, target suppliers. Review population of data as scheme is planned	Information for Choice programme team	Year 2 (March/April)	Disability
Fair access to the hospital travel scheme	Consultation on the hospital travel cost scheme complete. Understand the impact of changes to the scheme	Information for Choice programme team	Year 2 (December)	All
Policies initiated with appropriate consideration of equality issues and avoidance of discrimination	Include EqIA in the policy initiation process	Patient experience programme	Year 1 (April)	All
Policies initiated with appropriate consideration of equality issues and avoidance of discrimination	Monitor EqIA process for all policies in the programme	Patient experience programme	Year 1 (October)	All

Goal 4. To improve the capacity, capability and efficiency of the health and social care system

Outcome	Action	Responsibility	Timescale	Strands
Equal access to dental care	Remind PCTs of their Single Equality Scheme responsibilities and that they apply to dentistry	Dental team	Year 1	All
Equality integrated into research	Revisit research and development line on race equality and mainstreaming	Research and development	Year 1	Race
Equality integrated into research	Revisit DH research governance framework – check that all six strands are included	Research and development	Year 1	All
Equality integrated into research	Communicate with NHS-funded research and development programmes	Research and development	Year 1	All

Goal 4. To improve the capacity, capability and efficiency of the health and social care system *(continued)*

Outcome	Action	Responsibility	Timescale	Strands
A new equality-proofed commercial strategy and Agency for DH and NHS	Ensure that the remit and scope adequately reflect the equality and human rights agenda and requirements as part of the commercial process	DH commercial directorate/ Purchasing and Supply Agency (PASA)	Year 1 (April)	All
Equal treatment of mental health patients	Improve monitoring data from mental health review tribunal	Mental health team (with Department for Constitutional Affairs)	Year 2	Race
Implement a commercial strategy for DH and NHS	Ensure reference to equality/human rights is included in contract templates; provide training to agency staff and NHS; provide model contract clauses; provide legal advice; ensure communication policy is subject to equality/human rights gateway review	NHS commercial agency	Year 2 (April)	All
Review results of monitoring equality/ human rights implications and implementation of commercial strategy	Collect, collate and draw conclusions from data; draw up action plan	NHS commercial agency	Monitor over three-year period and formal review Year 3 (April)	All
Proactive communication advice to policy colleagues on providing access to information	Appropriate training for communications staff	Communications directorate and Central Office of Information	Year 1	All

Goal 5. To ensure systems reform, service modernisation, IT investment and new staff contracts deliver improved quality and value for money

Outcome	Action	Responsibility	Timescale	Strands
Effective consultation	Ensure monitoring requirements are understood and built in as a requirement to education programmes accompanying implementation	Stakeholder engagement	Year 1	All
No unintended consequences re PSA targets, linked to LDP lives	EqIAs. Work on Comprehensive Spending Review currently ongoing	Policy leads, policy hub	Year 1	
Ensure that NHS PASA and its successor body have the ability to meet the employment requirements of the Single Equality Scheme	Review reporting and inclusion in Human Resources system	PASA	Year 1 (April)	All
Fair implementation of *Our health, our care, our say* White Paper	Gather information on the consideration and completion of EqIAs by policy leads	White Paper implementation team	Year 1	All
World-class commissioning of health and social care services	Ensure that all aspects of the practice-based commissioning (PBC) implementation plan promote equality and avoid discrimination	PBC implementation team	Year 1	All
Fair access to mental health services	Use implementation of the Mental Health Bill to embed best practice from DRE/Race Equality Impact Assessment	HCP/mental health team	Year 2	Race
Equality embedded in policy making	Find appropriate methods of monitoring new and implemented policies	Commissioning gateway, EHRG to explore	Year 1	All
Equality integral to policy making	Deliver gateway timeline and then rolling programme, eg research and development, stakeholder engagement, project management, pilot, launch, review, evaluation, EqIA	Office of Government Commerce (OGC) gateway process	Years 1 and 2	All
Equality integral to policy making	Following review, build equality into new gateway enhancement where necessary gaps identified in line with continuous improvement	OGC gateway process	Year 3	All

Goal 6. To improve the service we provide as a department of state to – and on behalf of – ministers and the public, nationally and internationally

Outcome	Action	Responsibility	Timescale	Strands
DH compliance with legislation	Include impact assessment heading as standard in policy briefings and submissions	Ministerial submissions/ PR. Office	Year 1	All
Equality integral to policy-making processes	Assess opportunities for better/more effective action in policy making and policy governance in DH; how we compare ourselves with other government departments; trawl for legislation; explore developing an all-encompassing impact assessment toolkit for departments with the Cabinet Office as part of the regulatory impact assessment (RIA) revision work; forward plan/central programme office record of key policies; submission template; policy skills training			
Better policy making to include Single Equality Scheme	Develop business improvement plan; all staff engagement and buy-in (consultation process)	Business partner teams	Year 1	Race, disability, gender, age
Assess application of EqIAs to new DH policy	Performance monitor policy leads on carrying out EqIAs. Include check on internal database for external gateway-approved communications/policies	Departmental Management Board and external gateway	Year 1	All
Improved application of EqIAs to new DH policy	Raise awareness of EqIAs as part of mainstream systems and impact assessments, RIA. EHRG involvement in external gateway training	EHRG and external gateway	Year 1	All
Equality integral to policy making	Improve integration/ embedding of EqIA in policy initiation process. Ensure that external gateway is not seen to be the last line of defence	Policy hub and EHRG	Year 1 (March)	All

Goal 6. To improve the service we provide as a department of state to – and on behalf of – ministers and the public, nationally and internationally *(continued)*

Outcome	Action	Responsibility	Timescale	Strands
Equality mainstreamed into project management	Integrate equality into project management materials	Programme office	Year 1	All
Embed equality as part of business improvement	Co-ordinate strategic approach to Race Equality Scheme/Single Equality Scheme Action Plan across EI&G directorate	EI&PL SMT	Year 1 (January)	All
Business improvement	Co-ordinate strategic approach to agreeing Race Equality Action Plan across directorate	Business Development Unit	Year 1 (January)	All
Effectively monitor new and implemented policies	Resolve conflict between the need to gather evidence and the corporate limitations on central collection. Need to find appropriate methods of monitoring new and implemented policies	External gateway, ROCA and EHRG	Year 1	All
Fairer mental health services	Resolve how to manage disability assessment vis-à-vis the introduction of the BIU	Mental health team	Year 1	Disability
Fairer mental health services	Think about whether compulsion in SCT contradicts the requirements of EqIA and resolve this	Mental health team	Year 1	All
Equality integrated in contractual arrangements	DH standard contracts with consultants, etc and its service level agreement with NHS should include specifications on the duty to promote equality	Procurement	Year 1	All
Better targeted consumer information to BME disability audiences	Review and analyse current practice	Communi-cations/ information services	Year 1	Race, disability
Equality in direct access to DH (eg correspondence, telephone calls)	Sample/survey a number of correspondents	Customer services directorate	Year 1 and ongoing	All

Goal 7. To develop departmental capability and efficiency and cement our reputation as an organisation that it is good to do business with and a good place to work

Outcome	Action	Responsibility	Timescale	Strands
Improved leadership behaviour on diversity	Include diversity module in existing leadership programmes	Human resources	Year 1 (April)	All
Better representation of under-represented groups in DH's workforce	Review progress on 10-point plan targets	Human resources	Year 1 (June)	All
Fair employment policies	Review of human resources policy framework to ensure that it is fully compliant with all new duties, including determining whether a full EqIA is appropriate for any new human resources policy	Human resources	Year 1 (January)	All
Equal treatment of all DH employees	Consideration of all areas of the workforce agenda for evidence of any equality impact (evidence gaps identified)	Director general of workforce	Year 3 (April)	All
Improved data as a basis for action on diversity issues	Analyse exit data and review whether DH is capturing meaningful and comprehensive information	Human resources	Year 1 (March)	All
Fair recruitment practices	Include diversity training as part of the roll-out of the new resourcing project	Human resources	Year 1 (April)	All
Better representation of under-represented groups in more senior roles	Further development of positive action initiatives ahead of talent scheme launch	Human resources	Year 1 (October)	All
Fair employment practices	Revise guidance on procurement process (Delphi site)	Procurement	Year 1	All
Fair reward and pay strategy	Address pay anomalies identified in equal pay review; consult trade unions and agree prioritised pay adjustment/policy changes	Human resources	Year 1 (September)	All

Goal 7. To develop departmental capability and efficiency and cement our reputation as an organisation that it is good to do business with and a good place to work *(continued)*

Outcome	Action	Responsibility	Timescale	Strands
Fair local pay policy	Contract business partners to scope the feasibility of a project to develop a local pay policy consistent with DH policy	Human resources	Year 1 (March)	All
Fair performance management systems	Changes across Programme Project Management equality issues mainstreamed. Project Initiation Document risk assessment	EHRG	Year 1	All

DH Department of Health

278511 1p 0.5k Dec 06
Produced by COI for the Department of Health

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